
From: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR)
Sent: 1/17/2019 12:09:33 PM
To: Loschen, Wayne (CDC jhuapl.edu)
Subject: RE: All Traffic Related v2 CCDD Category

attachments\70429451DDCB4C37_AllTrafficCCDDv2_01.17.19.txt

Yes, sorry! I've updated the attachment to include that portion also.

Natasha, thanks for weighing in on the name. I agree that keeping it the same as the v1 would be least confusing for folks.

ZACHARY STEIN, MPH
Syndromic Surveillance Analyst
ICF Contractor, CDC BioSense
oru8@cdc.gov

From: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>
Sent: Thursday, January 17, 2019 3:03 PM
To: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Close, Natasha (CDC doh.wa.gov) <natasha.close@doh.wa.gov>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Also – Zach,

The file is missing the SQL part.

Wayne

Wayne Loschen
Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

From: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Sent: Thursday, January 17, 2019 2:05 PM
To: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>
Cc: Close, Natasha (CDC doh.wa.gov) <natasha.close@doh.wa.gov>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: All Traffic Related v2 CCDD Category

Wayne,

Please find Natasha's All Traffic Related v2 in the attached document. Please let me know if you have any questions about it.

Thank you!
Zach

ZACHARY STEIN, MPH
Syndromic Surveillance Analyst

ICF Contractor, BioSense Platform
Center for Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention (CDC)
316.371.3945
oru8@cdc.gov

_____
From: Mobley, Kayla
Sent: 1/16/2019 12:53:36 PM
To: Bryan, Zandt (DOH)
Subject: RE: quick budget question - need response by or before 3pm

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attachments\8D473975F8D24266_image006.jpg

attachments\9B415604E8E04931_image004.jpg

attachments\2F6C6671D07A4EFB_image002.jpg

attachments\B2845536D18F4F60_image008.jpg

attachments\BF8664B52EE4477E_image010.jpg

attachments\ECD62FD9C93B4C4E_image007.jpg

attachments\138306C5939A4B34_image012.jpg

Hey there, Zandt:

I'm the math-y type person here in Public Health, and I'm trying to help Dana get you the answers you need. I have a couple of questions:

1. Are you looking for total FTE funded by your portion of the grant the past cycle, or the upcoming Jan-Jun 2019 cycle?
a. Do you need the FTE total by employee, or just a net FTE total?
2. Are your portions described in the SOW as specific tasks? I'm assuming it's all tasks except SSP, but want to make sure.
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TASK: PREV-1a State HIV Prev TASK: PREV-1b AAPPS TASK: PREV-1c ADAP RebateTASK: SSP-1 State HIV Prev

b. Jan-Jun 2019 tasks:
TASK: SSP TASK: Clark County Mobile Syringe TASK: Safer Syringe Disposal TASK: HIV/STD Prev - State HIV Prevention TASK: HIV/STD Prev - HIV Prevention (Cat A) TASK: HIV Positive (+) Prevention Activities

Thank you!
Kayla
<https://www.clark.wa.gov/>

Kayla Mobley
Senior Financial Management Analyst
PUBLIC HEALTH

564.397.8235

<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>
<https://twitter.com/ClarkCoWA> <https://www.youtube.com/user/ClarkCoWa/>

From: Bryan, Zandt (DOH) [mailto:Zandt.Bryan@DOH.WA.GOV]
Sent: Wednesday, January 16, 2019 11:56 AM
To: Nguyen, Dana; Czapla, Monica
Cc: Miller, Katrina (DOH)
Subject: RE: quick budget question - need response by or before 3pm

Great question – I wasn't clear enough, as I was moving quickly and forgot to qualify that. Thank you.

I'm talking about non-SSP staff – DIS or surveillance or program manager.

From: Nguyen, Dana [mailto:Dana.Nguyen@clark.wa.gov]
Sent: Wednesday, January 16, 2019 11:52 AM
To: Bryan, Zandt (DOH); Czapla, Monica
Cc: Miller, Katrina (DOH)
Subject: RE: quick budget question - need response by or before 3pm

Zandt,
Would you be able to provide the specific items in the Scope of Work fall under your specific contract? I believe that you are referring to all HIV/STD line items, correct? And Sarah has all SSP items?

Dana C. Nguyen BSN, RN, CIC
Infection Control Practitioner, Program Coordinator II
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564.397.8080 fax (note: our office area code has changed)
dana.nguyen@clark.wa.gov

From: Bryan, Zandt (DOH) [mailto:Zandt.Bryan@DOH.WA.GOV]
Sent: Wednesday, January 16, 2019 11:05 AM
To: Czapla, Monica; Nguyen, Dana
Cc: Miller, Katrina (DOH)
Subject: quick budget question - need response by or before 3pm
Importance: High

Good morning, Monica, Dana:

About how many FTE in your program would you say the funds in the DOH contract I manage with you currently support in your program?

Thanks for any rapid response you can provide.
-z.

Zandt Bryan (pronouns: he/him)

Infectious Disease Field Services Coordinator
Washington Department of Health
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F: (360) 236-3470

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This e-mail and related attachments and any response may be subject to public disclosure under state law.

From: Close, Natasha (DOH)
Sent: 1/16/2019 4:26:00 PM
To: Idaikkadar, Nimi (CDC/DDPHSS/CSELS/DHIS)
Cc:
Subject: RE: pregnancy related work - our first query.

Hi Nimi,

Thanks for reaching out and sharing your draft definition.

The reason I posted was because one of our EIS officers (Henry Hjuguna) is attempting to assess opioid use/abuse/dependence during pregnancy. He is working to isolate patients whose records indicate they are pregnant at the time of visit and then wants to assess how frequently opioids are mentioned. He is focusing on EDs/Inpatient, but since we have quite a bit of outpatient clinic data, I think that could be interesting to look at too. He has done quite a bit of work already to look at neonatal abstinence syndrome in our hospital discharge data. Anyways, I've seen his proposal but not sure when he is planning to get started on the project.

I personally didn't have any pregnancy-related projects in mind, but I do think it would be of value to create a definition that identifies women who are pregnant at the time of their visit, especially since we don't get an indicator of pregnancy status. Seems like pregnancy comes up for just about any topic in terms of risk factors. I'd be happy to work with you to evaluate/refine the syndrome definition. I'd also love to hear more about the collaboration you are forming with DRH and what topics you are focusing on. This may help with forming some local collaboration with our maternal and child health colleagues.

Thanks,
Natasha

Natasha Close, MPH
Surveillance Epidemiologist
Disease Control and Health Statistics
Washington State Department of Health
natasha.close@doh.wa.gov
206-430-0617 | www.doh.wa.gov

From: Idaikkadar, Nimi (CDC/DDPHSS/CSELS/DHIS) [mailto:yrq8@cdc.gov]
Sent: Friday, January 11, 2019 8:13 AM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Subject: pregnancy related work - our first query.

Good morning Natasha,

I hope you are doing well and having a good start to the new year. Sorry for the delayed response. I was so happy to see your post on pregnancy related visits because we are about to start collaborating with division of reproductive health (DRH) on many public health topics. We showed them first draft of a pregnancy syndrome in ESSENCE and how it can be used. We (nssp) create the syndrome to show them and how to create a syndrome/query. It is a very broad broad query. I would be more than happy to collaborate with you on the pregnancy related topic and also bring some of the epis in DRH that can provide some expertise. Your thoughts?

Here is our first draft of the query.

^pregn^,andnot,^not
preg^,or,^prenatal^,or,^miscarriage^,or,^caesarean^,or,^abortion^,or,^amniotic^,or,^breech^,or,^ec
]labor[ ]
^,or,^placenta^,or,^eclampsia^,or,^colostrum^,or,^umbilical^,or,^amniocentesis^,or,^macrosomia^,o
hicks^,or,^cephalopelvic disproportion^,or,^c section^,or,^cord
prolapse^,or,^doula^,or,^epidural^,or,^ectopic^,or,^fetal
distress^,or,^episotomy^,or,^[;/]Z34.0[0123]^,or,^[;/]Z34.8[0123]^,or,^[;/
]Z34.9[0123]^,or,^[;/]N96^,or,^[;/]o0[04789]^,or,^[;/]o1[2356]^,or,^[;/
]o2[012345689]^,or,^obstetric^,or,^pregnancy induced^,or,^obgyn^,or,^supervision
encounter^,or,^[;/]o3[01]^,or,^[;/]o3[01]^,or,^[;/]021[01289]^,or,^[;/
]o60[0123456789]^,or,^[;/]o7[01234567]^,or,^[;/]08[02]^,or,^[;/]09[489A],,^[;/
]03[5678]^,or,^[;/]Z380[01]^,or,^[;/]Z38[124578]^,or,^[;/]Z38[61-69]^,or,^[;/
]Z38[30-31]^

Best,

Nimi Idaikkadar
Surveillance and Data Science Team
Surveillance and Data Branch
Division of Health Informatics and Surveillance
Center for Surveillance, Epidemiology, and Laboratory Services
CDC Office of Public Health Scientific Services

From: erin dzpublicaffairs.com
Sent: 1/16/2019 10:52:56 PM
To: alex@alexalstonconsulting.com,Altman, Joan (HBE),chris@bandoliconsulting.com,Banks, Brad,brackenbury@comcast.net,Brady, Brynn (DOHi),Burkland, Anne (DOHi),Lyset@cadenaconsulting.com,vic@copcwa.org,Cooper, Kelly (DOH),Corbridge, Ian (DOHi),erin dzpublicaffairs.com,Hugh.ewart@seattlechildrens.org,NickFederici@gmail.com,kristen.federici@providence.
Carrie (DOHi),EGonzalez@wslc.org,Gregory, Brittany (ATG),Gupta, Rashi (GOV),ehallock@fightcrime.org,lindsay.hovind@heart.org,Johnson, Mona (OSPI),rebecca@rebeccanjohnson.com,kak@wsma.org,laurielippold@gmail.com,Lisicich, Priscilla (non-ATG)(SafeStreets),McGill, Jason (GOV),mary.mchale@cancer.org,amondi@arcorafoundation.org,abby@abbymoorepa.com,jmoschella@wta.
Jennifer (DOHi),carrie.nyssen@lung.org,O'Neill, Shawn (HCA),Peterson, Julie (DOHi),April.Putney@kingcounty.gov,Matthew.Richardson@nursefamilypartnership.org,Shaw, Michael,alexa.r.silver@gmail.com,smith.melaniej@gmail.com,Stokes, Genevieve (DCYF),ategen@TobaccoFreeKids.org,Thompson, Chris (LCB),Trudeau, Yasmin (ATG),amber@ulvenesconsulting.com,Futurewise - Bryce,Black, Ryan (DOH),Brown, Wendy (RCO)
Subject: Prevention Alliance 2019 Bill Tracker for tomorrow's meeting

attachments\7637625015C14128_2019 PA Strategy List.xlsx

attachments\0893C89B2F00452B_2019 Detailed PA Strategy Buckets.docx

Good evening!

We have made it to Thursday, which means warm Thai food is just a few hours away!

Attached please find the 2019 PA Strategy sheet updated as of this morning. I have also attached a cheat sheet document that lists out the strategies that are more buckets and need a little more detail. It currently has the Governor's budget detail for these buckets, but we will continue to build them out with bills.

For those who are new (and there are a few of you!), the flow of the PA meetings is that people come in, grab food and we run through the bill tracking spreadsheet so strategy leads can provide updates on their issues. We have printed copies of the tracker for you in the room. If you are only able to attend part of the meeting, please be sure to let us (Kristen & Erin) know your timing so we can do our best to accommodate. If you are not able to attend at all, please send us an update in advance so we can share with the group. On Sunday nights, we email out the list again and call out upcoming hearings for the week with actions to take on bills that have been scheduled. If you have any questions on this process, don't hesitate to ask!

Finally, below please find the Rules of Conduct for our Thursday meetings. We formalized these rules last year and will be continuing to use them again this session. We will talk through these at the beginning of our first meeting.

See you tomorrow at noon!

Erin & Kristen
Prevention Alliance Co-Chairs

Prevention Alliance Rules of Conduct-
The following serve as rules of conduct for the weekly session meetings in Olympia.
* The Prevention Alliance is a safe space built upon trust where we can collaborate on

our shared issues during session.
* Members who are leads on a strategy will provide timely updates on their issue, both to the lobbyist group at the Thursday meetings, and also to the Prevention Alliance chair throughout each week during session as changes occur on your issue.
* We cannot go into the hall to have conversations – it is disruptive to the offices near our meeting space.
* We cannot have side conversations in the room as the sound travels.
* We convene and provide food with the focus of getting through our work and review the strategy list between 12:00-1:00. Members are welcome to come early (11:30-12:00) or stay after (1:00-1:30, or if the meeting ends early) to network and have additional conversations or chat with other members of the Prevention Alliance.
* Texting and emailing during the meeting is completely acceptable. We have been provided with the wireless code for the room to help with connectivity. The wireless code is included in the calendar appointment and is on the table in the room.
* It is always appreciated if you are able arrive early to help set up or stay for a few minutes and help clean up after.
* For contract lobbyists, you are there for a specific client, please only speak to issues on their behalf and not on behalf of other clients who are not Prevention Alliance members (unless directly asked).

Conflicts of Interest:
Given the nature of our work, it is expected that conflicts of interest will arise from time to time. If there is a conflict of interest:
* We expect the conflict of interest to be disclosed and for the lobbyist to step out of the room when the strategy they are conflicted on is being discussed.
* If there is a perception from another Prevention Alliance member that you have a conflict, we ask that you leave the room during the identified strategy. Just because you may not see a conflict does not mean everyone is ok with it and it is important that we maintain the 'safe space' atmosphere of the Prevention Alliance.
* If these rules are not something you can abide by or you have questions about potential conflicts please don't hesitate to talk to Erin or Julie.

From: Nguyen, Dana
Sent: 1/16/2019 11:51:46 AM
To: Bryan, Zandt (DOH),Czapla, Monica
Subject: RE: quick budget question - need response by or before 3pm


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attachments\14890D1046974421_image009.jpg


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Zandt,
Would you be able to provide the specific items in the Scope of Work fall under your specific contract? I believe that you are referring to all HIV/STD line items, correct? And Sarah has all SSP items?

Dana C. Nguyen BSN, RN, CIC
Infection Control Practitioner, Program Coordinator II
COMMUNICABLE DISEASE

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<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>
<https://twitter.com/ClarkCoWA> <https://www.youtube.com/user/ClarkCoWa/>

From: Bryan, Zandt (DOH) [mailto:Zandt.Bryan@DOH.WA.GOV]
Sent: Wednesday, January 16, 2019 11:05 AM
To: Czapla, Monica; Nguyen, Dana
Cc: Miller, Katrina (DOH)
Subject: quick budget question - need response by or before 3pm
Importance: High

Good morning, Monica, Dana:

About how many FTE in your program would you say the funds in the DOH contract I manage with you currently support in your program?

Thanks for any rapid response you can provide.
-z.

Zandt Bryan (pronouns: he/him)
Infectious Disease Field Services Coordinator
Washington Department of Health
PO Box 47840
Olympia, WA 98504

Zandt.Bryan@doh.wa.gov
T: (360) 890-5816
F: (360) 236-3470

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From: Mobley, Kayla
Sent: 1/16/2019 4:20:41 PM
To: Bryan, Zandt (DOH)
Subject: RE: quick budget question - need response by or before 3pm

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attachments\307769F016A744BF_image002.jpg
attachments\E3C6617BDE294325_image001.jpg
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attachments\FC9D3E89FBA5472E_image007.jpg
attachments\688F180BEA59492C_image005.jpg
attachments\2977F32DFDF5410E_image006.jpg
attachments\2A3D9879A52347B7_image003.jpg

Zandt,

I would estimate that the grants (excluding SSP) support approximately .8 FTE

Thank you,
Kayla

From: Bryan, Zandt (DOH) [mailto:Zandt.Bryan@DOH.WA.GOV]
Sent: Wednesday, January 16, 2019 1:08 PM
To: Mobley, Kayla
Cc: Nguyen, Dana
Subject: RE: quick budget question - need response by or before 3pm

Hi Kayla: Thanks for helping us. To answer your questions:

1. Upcoming Jan-Jun 2019 cycle is fine
a. Net FTE total
2. You are correct that it's all tasks except SSP.

Thanks –
z.

From: Mobley, Kayla [mailto:Kayla.Mobley@clark.wa.gov]
Sent: Wednesday, January 16, 2019 12:53 PM
To: Bryan, Zandt (DOH)
Cc: Nguyen, Dana
Subject: RE: quick budget question - need response by or before 3pm

Hey there, Zandt:

I'm the math-y type person here in Public Health, and I'm trying to help Dana get you the answers you need. I have a couple of questions:

1. Are you looking for total FTE funded by your portion of the grant the past cycle, or the

upcoming Jan-Jun 2019 cycle?
a. Do you need the FTE total by employee, or just a net FTE total?
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a. Previous cycle tasks 2018:
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Kayla
<https://www.clark.wa.gov/>

Kayla Mobley
Senior Financial Management Analyst
PUBLIC HEALTH

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Great question – I wasn't clear enough, as I was moving quickly and forgot to qualify that. Thank you.

I'm talking about non-SSP staff – DIS or surveillance or program manager.

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To: Bryan, Zandt (DOH); Czapla, Monica
Cc: Miller, Katrina (DOH)
Subject: RE: quick budget question - need response by or before 3pm

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Dana C. Nguyen BSN, RN, CIC
Infection Control Practitioner, Program Coordinator II

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From: Close, Natasha (DOH)
Sent: 1/18/2019 1:51:00 PM
To: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS)
Subject: RE: All Traffic Related v2 CCDD Category

Yes, I would say ESSENCE has been helpful. We are using it for active case finding for really suspicious records, especially those outside the main outbreak area as there may be spread. Nothing we've followed-up on has panned out yet, but still good to know we have some awareness of what is going on in other areas of the state rather than just being sitting ducks. We are ensuring all the cases with measles diagnoses are known cases.

We are also using it to monitor people coming in because they heard something on the news and are worried or due to exposures (to monitor healthcare impacts and our messaging).

Have a good weekend!
natasha

From: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) [mailto:lyv8@cdc.gov]
Sent: Friday, January 18, 2019 11:01 AM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Cc: Loschen, Wayne (CDC jhuapl.edu) <wayne.loschen@jhuapl.edu>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Ah, I understand. I miss those days at the state level!

By chance, has ESSENCE been helpful at all with the measles outbreak?

Aaron

From: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Sent: Friday, January 18, 2019 1:53 PM
To: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Cc: Loschen, Wayne (CDC jhuapl.edu) <wayne.loschen@jhuapl.edu>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Subject: Re: All Traffic Related v2 CCDD Category

Ah, ok. So maybe not until Tuesday...

We are working on a measles outbreak so weekends/holidays are not quite as meaningful at the moment. :)
Natasha Close, MPH
Suveillance Epidemiologist
Division of Disease Control and Health Statistics
Washington State Department of Health
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<https://twitter.com/wadepthealth?lang=en>
<https://www.facebook.com/WADeptHealth/>
<https://www.instagram.com/wadepthealth/>
<https://www.youtube.com/channel/UCTSCpezTD0TjiiAOuJY7f5w/doh>
<https://medium.com/@WADeptHealth>

On Jan 18, 2019, at 10:49 AM, Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS)

<lyv8@cdc.gov> wrote:
Yeah, and remember that Monday is a holiday, at least for us, but if Wayne is working and it's done perhaps he'll kick off the last step to re-build the cubes? After that it will be ready to use.

Aaron

From: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>
Sent: Friday, January 18, 2019 1:47 PM
To: Close, Natasha (CDC doh.wa.gov) <natasha.close@doh.wa.gov>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Correct. It is running now.

I don't know if it will finish by Monday (we added 5 new categories), but it will be running all weekend for sure.

Wayne

Wayne Loschen
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11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

From: Close, Natasha (DOH) <Natasha.Close@doh.wa.gov>
Sent: Friday, January 18, 2019 1:45 PM
To: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

I see you've put in the definition and am patiently waiting to use it as I assume the tables are building. Should I expect this process to complete by Monday?

Thanks!
natasha

From: Close, Natasha (DOH)
Sent: Thursday, January 17, 2019 11:32 AM
To: 'Loschen, Wayne A.' <Wayne.Loschen@jhuapl.edu>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Yay! So excited!!!!! Thanks!

Natasha

From: Loschen, Wayne A. [mailto:Wayne.Loschen@jhuapl.edu]
Sent: Thursday, January 17, 2019 11:27 AM
To: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>; Kite Powell, Aaron

(CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Got it – thanks.

Wayne

Wayne Loschen
Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

From: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Sent: Thursday, January 17, 2019 2:05 PM
To: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>
Cc: Close, Natasha (CDC doh.wa.gov) <natasha.close@doh.wa.gov>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: All Traffic Related v2 CCDD Category

Wayne,

Please find Natasha's All Traffic Related v2 in the attached document. Please let me know if you have any questions about it.

Thank you!
Zach

ZACHARY STEIN, MPH
Syndromic Surveillance Analyst
ICF Contractor, BioSense Platform
Center for Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention (CDC)
316.371.3945
oru8@cdc.gov

From: Close, Natasha (DOH)
Sent: 1/17/2019 10:03:00 AM
To: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR)
Subject: RE: All Traffic CCDD v2

Sure, that should be fine. Thank you!

Natasha

From: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) [mailto:oru8@cdc.gov]
Sent: Thursday, January 17, 2019 8:10 AM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic CCDD v2

Everything looks good. I'll get this sent to JHU today and they will start the CCDD Category process.

There is a duplicate term in the query. Do you mind if I remove the duplicate before sending it?

/]V892x^,or,^[;/]Y32^,or,^[;/]Y32^,or,^[;/]Y0[23].0x^,or,^Y0[

Thanks again!
Zach

ZACHARY STEIN, MPH
Syndromic Surveillance Analyst
ICF Contractor, CDC BioSense
oru8@cdc.gov

From: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Sent: Monday, January 14, 2019 6:46 PM
To: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic CCDD v2

Also forgot to mention, that until I added the exclusion for records containing the term "nontraffic", I got the same exact records as I got with the original update I sent you and Aaron. Even then, the removal of records containing nontraffic resulted in 0.15% fewer records. Just wanted to let you know that the tweaks I made in the latest version really didn't make any difference, so you should haven't to spend a ton of time re-reviewing it.

Thanks,
Natasha

From: Close, Natasha (DOH)
Sent: Monday, January 14, 2019 3:41 PM
To: 'Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR)' <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic CCDD v2

Yes, I would like an updated CCDD category put into place in NSSP ESSENCE using this updated definition. Unless anyone finds any major flaws, I don't anticipate making further updates to this particular definition. I know people might like to have more specific traffic-related definitions, but I don't have solid plans *yet* to do that work.

I'm working on an analysis of traffic-related injuries in outpatient settings to assess what value this data may have for understanding traffic-related injuries, but since I learned that the v1 CCDD category has some downfalls, particularly for data coming from outpatient settings, I put that work on hold in hopes of getting v2 in place so that I can continue that work without putting a ton of strain on the system.

Thanks,
Natasha

From: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) [mailto:oru8@cdc.gov]
Sent: Monday, January 14, 2019 2:53 PM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic CCDD v2

Everything looks good after a quick look. I'll look it over more closely tomorrow.

Since I came into this a bit after you and Aaron had been talking, what is your goal or next step in this? Are you wanting it incorporated as an updated CCDD category?

Thanks!
Zach

ZACHARY STEIN, MPH
Syndromic Surveillance Analyst
ICF Contractor, CDC BioSense
oru8@cdc.gov

From: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Sent: Monday, January 14, 2019 5:24 PM
To: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic CCDD v2

Hi Zach,

I responded to your comments below. I made a couple of small revisions per your suggestion and explored, but decided against some of the others.

I'm picking up quite a few more bike accidents due to the code V29.9. I don't have a ton of info to determine whether these are something we want to include other than the code description indicates they are "traffic" related. Also, I realized I'm picking up the term "nontraffic" when I search for "traffic", so I excluded records containing "nontraffic"

Attached is what I propose for v2.

Thanks,
Natasha

From: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) [mailto:oru8@cdc.gov]
Sent: Friday, January 4, 2019 11:02 AM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic CCDD v2

Natasha,

Thanks for clearing that up! I figured it was to get rid of trunk-related CCs but wasn't positive. It also likes to interpret it as "Drunk" sometimes too.

I did a bit of further investigating into the ^Motorcycle crash^ vs ^Crash^Motorcycle^ vs ^Crash^,AND,^Motorcycle^. For the last 90 days in the CCQV Data, ^Motorcycle Crash^ returned 2,439 visits and ^Motorcycle^,AND,^Crash^ returned 2,663 visits - only an increase of 224 visits. Reviewing only these 224 additional visits, most of these look like true positive visits you'd want to capture. To check one last thing, I reviewed the CCDD Category labels on these visits and only 2 of these 224 weren't picked up by the All Traffic V1 query.
All this to say, you collect most visits with the format you have and those positive visits that remain appear to nearly all get captured by other methods in your query.

Once you get a final V2, let me know and I'll get it moved forward in the process.

Thanks again,
Zach

ZACHARY STEIN, MPH
Syndromic Surveillance Analyst
ICF Contractor, CDC BioSense
oru8@cdc.gov

From: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Sent: Thursday, January 3, 2019 7:47 PM
To: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic CCDD v2

Hi Zach,

Thanks for your thorough review of my query. I know it's a lot to digest. I'll review your comments to determine if we should make any further modifications before we solidify it.

For item 8, the issue was that I'm including the text string of MotorVehicle and searching subcategory_flat to capture any records that were flagged with pre-existing ESSENCE CC subsyndrome, rather than trying to recreate the CC search that already exists. Unfortunately, that subsyndrome gives a weight of 10 to records containing the word "truck". Since ESSENCE does fuzzy matching and allows for 1 letter differences, it flags any records with "trunk" in the CC as a MotorVehicle related record. Ordinarily this might not be a big issue, but WA brings in a large amount of outpatient clinic data, including a number of specialty clinics. We receive a substantial number of records from these specialty clinics that have "trunk" in the CC which are often cancer visits. Since I was specifically doing an analysis on data received from these outpatient settings to assess their value, I felt this was obscuring my analysis and would like to exclude those records from being pulled in at all. For the typical site that only receives ED data, it probably wouldn't be necessary to include. I did explore whether we would lose many traffic-related records that legitimately contain the word "trunk" (as a part of the car) but I didn't really dig anything up.

Thanks again,
Natasha

From: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) [mailto:oru8@cdc.gov]
Sent: Thursday, January 3, 2019 4:00 PM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>

Subject: All Traffic CCDD v2

Natasha,
I started in on the All Traffic V2 CCDD Category, but then didn't finish typing it up. Sorry for the delay!

1. In the ^V[.]^,ANDNOT,^[a-z]V^, there's a chance of negating based on words like have, dove, over, etc. that can be remedied by adding the bracket onto the negation to make it ^V[.]^,ANDNOT,^[a-z]V[.]^ Good suggestion, made that change.
2. Have you considered the following?
a. ^Transport Accident^ to capture those visits where the hospital sends the direct interpretation of the ICD10 as the "Chief Complaint": I think if they send the ICD10 description in the CC, they will likely have the corresponding ICD code in the diagnosis field so this wouldn't be necessary. I did look though. Only 38 records had this phrase in CC Hx in 90 days, only 5 of which weren't already being flagged by the existing CCDD category. 2 of those appear to be car vs. pedestrian events which I am capturing but I didn't include the code that is being used for these (V09.9XXA). In general, I think I included most codes that have "traffic" in the description but not "transport". CDC has this particular code classified as a "Pedestrian, other". As I mentioned in my original email to Aaron, there are some codes (e.g., V09.3 that mention a traffic accident, but I didn't include them because CDC didn't classify them as a "Motor vehicle – traffic". Honestly, I'm not familiar enough with coding to tell the difference between some of these codes and why one would be used but not another. There is a set of MVT codes that DO talk about pedestrians and cars, and I'm capturing those.

The other 2 had the code Z04.1 - Encounter for examination and observation following transport accident. This is a pretty vague code, but at least these two records are for car accidents. I searched for Z04.1 specifically. Most of these are already captured. For the ones that weren't and have more detail, many appear to be mvcs. Interestingly, most involve law enforcement and obtaining medical clearance. Again, it's such a small number that I'm not sure it's worth including and worry about some noise.

I think I'm not going to add this phrase or these additional codes.

b. ^Auto Accident^ or ^Automobile^: By including any records flagged with the CC Subsyndrome MotorVehicleTraffic, I'm already capturing records with these terms. The only record that didn't get captured related to a burn from an air bag…which did deploy after an MVC. I learned a new code: W22.10XA Striking against or struck by unspecified automobile airbag, initial encounter. Going to let this one go I think.
3. What are your thoughts on ^Motorcycle crash^ vs ^Crash^Motorcycle^ vs ^Crash^,AND,^Motorcycle^? It doesn't looks like this captures any additional records in our data, but it doesn't seem like it would hurt anything to go with the more flexible form. I think my only hesitation is that this isn't consistent with all the other terms I included. I think I'd like to keep it the way it is. For our data at least, I don't think it will help.
4. Your V09.2[019]X code contains all possible options after the 4th place. This code could be shortened to V09.2. I see some comments about extending ICD10 to the Xth digit to ensure it doesn't pick up conflicting ICD9 codes so I'm assuming that's what is going on here. Yup, V09.2 is "infection with microorganisms resistant to macrolides" in ICD9 world. Keeping the specificity.
5. The X82 codes can be shortened to just ^[;/]X82^ . There aren't any conflicting ICD9 with this either. I think you're right. Just paranoia setting in. :-)
6. The Y32 codes can also be shortened to ^[;/]Y32^ without causing any foreseeable problems. Agreed, more paranoia. Or maybe I was just having fun writing out all the combos of codes in regex??? ;-)
7. I tried multiple forms to try and simplify both ICD10 codes and Key terms, but couldn't find a best way to accomplish that. It sure is a long complex code, but seems to be necessarily complex!

a. I tried to simplify many of the terms into "(,^Motor^,or,^vehicle^,or,^car^,),AND,(,^crash^,or,^accident^,)" and it pulled up some visits that your initial code didn't. Things like Crash Motorcycle, Crash Motor Vehicle, Motor Vehicle Collision, etc., except it brought in quite a few All Terrain Vehicle Accidents/Crashes. Removing these ATV visits, it only brings in an additional 5,000 ED visits over the last 90 days that your key terms didn't. For reference this is just a drop in the bucket since your All Traffic v1 brings in 630,000 visits in the same time period. Probably not worth the effort to try and add in. I like where you were going with this since it doesn't require specific phrases, but in looking at a sampling of our data, I think it's going to be hard to do the negations. Car is showing up in a lot of words (e.g., care, cardio, bradycardia, carried) and accidental apparently gets used a lot when these types of events happen. It could probably be done, but would be a pain do the necessary negations to remove false positives and, as you a say, only a small number of additional records that we want are captured by doing this.
8. Could you explain the purpose of the whole-query negation of ^Trunk^ in the Chief Complaint Updates field? I see a note in a previous email, but am not following the reasoning. Done in previous email

All around, it's a great query. I tried a number of my usual ways to improve/make it more concise but it appears you've thought of everything I normally try!

Looks great!
Zach

ZACHARY STEIN, MPH
Syndromic Surveillance Analyst
ICF Contractor, BioSense Platform
Center for Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention (CDC)
316.371.3945
oru8@cdc.gov

_____
From: Close, Natasha (DOH)
Sent: 1/18/2019 10:44:00 AM
To: Loschen, Wayne A.,Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR)
Subject: RE: All Traffic Related v2 CCDD Category

I see you've put in the definition and am patiently waiting to use it as I assume the tables are building. Should I expect this process to complete by Monday?

Thanks!
natasha

From: Close, Natasha (DOH)
Sent: Thursday, January 17, 2019 11:32 AM
To: 'Loschen, Wayne A.' <Wayne.Loschen@jhuapl.edu>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Yay! So excited!!!!! Thanks!

Natasha

From: Loschen, Wayne A. [mailto:Wayne.Loschen@jhuapl.edu]
Sent: Thursday, January 17, 2019 11:27 AM
To: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Got it – thanks.

Wayne

Wayne Loschen
Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

From: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Sent: Thursday, January 17, 2019 2:05 PM
To: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>
Cc: Close, Natasha (CDC doh.wa.gov) <natasha.close@doh.wa.gov>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: All Traffic Related v2 CCDD Category

Wayne,

Please find Natasha's All Traffic Related v2 in the attached document. Please let me know if you have any questions about it.

Thank you!
Zach

ZACHARY STEIN, MPH
Syndromic Surveillance Analyst
ICF Contractor, BioSense Platform
Center for Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention (CDC)
316.371.3945
oru8@cdc.gov

From: Chaput, Daniel (OS/ONC)
Sent: 1/17/2019 10:07:46 AM
To: Mitchell, Nina (CDC/DDPHSS/CSELS/OD) (CTR),Baumgartner, Chris J (DOH),Nelson, Ramona (DOH),Karras, Bryant T (DOH),Wickersham, Kevin P (DOH),Tandon, Sanjeev (CDC/DDPHSS/CSELS/OD),Daniel, James B. (HHS/CTO)
Cc:
Subject: Re: WA SyS - Opioid Crisis Grant - RHINO TA Request

attachments\F3CFF7EF5AA24144_image001.png

Note, I have seen no evidence the EHRs are failing to produce messages the conform to certification. I have heard there are configuration issues, connectivity issues etc., all work that is outside of certification. Dan

---

On: 17 January 2019 12:02,
"Mitchell, Nina (CDC/DDPHSS/CSELS/OD) (CTR)" <nai7@cdc.gov> wrote:

Notes

Hope this message finds you well. I know we've mentioned these sorts of issues before. I was rather hoping that by now vendors that are MU certified would be able to produce certified messages in the field. However, we've received a request from WA to help with their vendor problems that are also affecting their Opioid Overdose CoAg with the ESOOS program. I don't know all of the details and also am not sure who the proper contacts at ONC are now a days. Would you be able to assist in getting the vendors to provide the syndromic data as expected per the specifications?

DOH has two request for TA under for projects under Domain 3 of NCIPC. The first item also falls under Domain 2 of NCHHSTP.

1. 1.To support the development of geospatial visualizations for opioid overdose and risk factor data, we request training in ArcGIS and geospatial visualizations for our staff.
2.
3. 2. Several EHR vendors are having difficulty sending data for syndromic surveillance, limiting the representativeness of our syndromic surveillance data. We request that CDC work with the Office of the National Coordinator for Health Information Technology (HHS) to provide assistance to these vendors and ensure their capability to provide data. Vendors of concern include but are not limited to Athena Health, AllScripts, and eClinicalWorks.

Nina L. Mitchell BS, MS Health Informatics
Chenega Corporation-Expert Consultant
CDC, Center for Surveillance, Epidemiology and Laboratory Services (CSELS)
Century Center, Bldg. 2400 RM 6401.06
Atlanta, Georgia 30345, MS E-94
Phone 404-498-6558- Email nai7@cdc.gov

To submit questions or request technical assistance for Public Health issues related to the Electronic Health Record (EHR) Meaningful Use Incentive Programs please contact us at:meaningfuluse@cdc.gov

---

From: Alexa Silver
Sent: 1/21/2019 9:23:40 PM
To: Webb, Mike (ATG)
Subject: Re: Tobacco 21 - Next Steps

No, it was a voice vote. I thought I heard one or more no's (Becker and O'Ban?).

On Jan 21, 2019, at 8:33 PM, Webb, Mike (ATG) <MikeW@atg.wa.gov> wrote:

Great work!

Alexa, do you know he vote? I suppose we'll see it tomorrow.

Mike

Sent from my iPhone

On Jan 21, 2019, at 4:08 PM, Mary McHale <mary.mchale@cancer.org> wrote:

Great work, everyone!

Mary McHale
Washington Government Relations Director
206.674.4187 | m: 610.417.4746 | f: 206.285.5108

American Cancer Society Cancer Action Network, Inc.
555 11th Street NW Suite 300
Washington, DC 20004
fightcancer.org | 1.800.227.2345

From: Alexa Silver <alexa.r.silver@gmail.com>
Sent: Monday, January 21, 2019 4:03:38 PM
To: Mary McHale
Cc: Alma Gottlieb-McHale; Andrea Tull; Annie Tegen; Lauren Y Baba; Brittany Gregory; Brynn Brady; carrie dzpublicaffairs.com; Carrie Nyssen; chelsea@insightstrategicpartners.com; Kelly Cooper; David Foster; erin dzpublicaffairs.com; Alicia B Eyler; grace. henscheid; Julie Peterson; Kate White Tudor;

Katie Kolan; Lindsay Hovind; Webb, Mike (ATG); Jason McGill; Jim Justin; Patty Seib; Amber Oar Ulvenes
Subject: Re: Tobacco 21 - Next Steps

SB 5057 passed out of Senate Health & Long-Term Care this afternoon. They adopted an amendment to petition Congress to raise the age to 21 at the federal level, as well.

Alexa

Alexa Silver
alexa.r.silver@gmail.com
360-951-4564

On Jan 18, 2019, at 11:20 AM, Mary McHale <mary.mchale@cancer.org> wrote:

Hi all - general consensus is the Senate HLTC hearing on SB 5057 this morning went well. It was a bit broken up and our panels were scattered throughout the hearing. We also did not have as much time as the House hearing. But overall, testimony was great and we're happy with how things went.

From our 10:30 check in call, here are the updates and next steps:

* We keep hearing that both chambers want to run this quickly.
* Cleveland said she'd try to exec 5057 out on Monday depending on any amendments that may come up. We have not heard of any pending amendments.
* Cody has had initial conversations with Ormsby about scheduling 1074 in approps the week of 1/28

Electeds with whom to check in if you've got meetings coming up:
* Senate Rs, including Bailey, Rivers & O'Ban - they are sponsors but we will need keep confirming their support

* Cody - just check in on next steps after it goes through her committee

IMPORTANT: I am maintaining a vote tracker. As you meet with electeds and confirm their position, let me know either via text or email & I will update the document. My cell is listed below.

The vote tracker can be viewed here. If you have any edits, just let me know.

Mary McHale
Gender Pronouns: they/them
Washington Government Relations Director

206.674.4187 | m: 610.417.4746 | f: 206.285.5108

_____
American Cancer Society Cancer Action Network, Inc.
555 11th Street NW Suite 300
Washington, DC 20004
fightcancer.org | 1.800.227.2345

<https://www.fightcancer.org/>

_____
From: Close, Natasha (DOH)
Sent: 1/17/2019 12:06:00 PM
To: Loschen, Wayne A.,Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR)
Subject: RE: All Traffic Related v2 CCDD Category

Please use the same name just change it to v2 instead of v1 to reflect it's an update of that existing definition.

Natasha

From: Loschen, Wayne A. [mailto:Wayne.Loschen@jhuapl.edu]
Sent: Thursday, January 17, 2019 12:02 PM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Zach,

The current CCDD is called All Traffic Related v1

In this file, you called it: All Traffic Injury v2

Should it be Injury or Related?

Wayne

Wayne Loschen
Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

From: Close, Natasha (DOH) <Natasha.Close@doh.wa.gov>
Sent: Thursday, January 17, 2019 2:32 PM
To: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Yay! So excited!!!!! Thanks!

Natasha

From: Loschen, Wayne A. [mailto:Wayne.Loschen@jhuapl.edu]
Sent: Thursday, January 17, 2019 11:27 AM
To: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
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Subject: RE: All Traffic Related v2 CCDD Category

Got it – thanks.

Wayne

Wayne Loschen
Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

From: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Sent: Thursday, January 17, 2019 2:05 PM
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Cc: Close, Natasha (CDC doh.wa.gov) <natasha.close@doh.wa.gov>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: All Traffic Related v2 CCDD Category

Wayne,

Please find Natasha's All Traffic Related v2 in the attached document. Please let me know if you have any questions about it.

Thank you!
Zach

ZACHARY STEIN, MPH
Syndromic Surveillance Analyst
ICF Contractor, BioSense Platform
Center for Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention (CDC)
316.371.3945
oru8@cdc.gov

From: Davis, Jerrod (DOH)
Sent: 1/18/2019 2:26:29 PM
To: Eilers, Katie (DOHi),Wilson, Lyndia (DOHi),Flake, Marie D (DOH),Abplanalp, John (DOHi),Bodden, Jaime (DOHi),Boysun, Mike (DOH),Crutsinger-Perry, Elizabeth (DOH),Yu, Diana (DOHi),Dzedzy, Ed (DOHi),Everson, Teresa (DOHi),Goelz, Mary (DOHi),Harper, Tawney (DOH),Hollinsworth, Cindy (DOHi),Huynh, Mary (DOH CDC Assignee),Kirkpatrick, Vicki (DOHi),Lindquist, Scott W (DOH),Lofy, Kathy H (DOH),Melnick, Alan (DOHi),'monica.czapla@clark.wa.gov',Pecha, Monica J (DOH),Roberts, Michele (DOH),Turner, Susan (DOHi),Wolfe, Roxanne (DOHi),Worsham, Dennis (DOHi),York, Danette (DOHi),Turnberg, Wayne (DOH),Huriaux, Emalie (DOH),Hawkins, Vivian (DOH),Harry, Cynthia S (DOH),Allis, Donna (DOHi),Sjoberg, Susan (DOHi),'Narita, Masa','Forbes, Tesia','Kayla Scrivner','Nigel Turner'
Subject: FPHS CD Subgroup Phone Call on Tuesday (1/22 at Noon) - Agenda & Attachments

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attachments\9BCF0F20EC684CF8_CD planning team budget proposals_subgroup_1-18-19.pdf

Hello FPHS CD Subgroup Participants,

I'm looking forward to our FPHS CD Subgroup phone call next Tuesday (1/22) at Noon. Katie Eilers and I wanted to get some information to you in advance of the meeting. Katie and I have been working on some documents to help guide us through the assignment and beyond.

Background – Assignment from the FPHS Steering Committee

* Budget Request – WSALPHO, tribes, and public health partners will advocate for $100M for FPHS funding. Of this, ~$20M/biennium (already included in the Governor's Budget) is for maintenance of 2017 initial investment and tribal FPHS work ($12M initial investment; $3M lead; $3 PHSKC; $1.2M tribes; $0.8M SBOH, WSALPHO). Of the remaining $80M request, the SME subgroups are tasked to scrub/hone priorities and proposals focused on the following amounts and include rationale about why it is a top funding priority. Due to Marie & Jaime by 1/31.
* CD - $40M/biennium
* EH - $28M/biennium
* Assessment - $12M/biennium
* Discussion and feedback from lobbyists and partner advocates – the larger the ask the more likely funding amount will continue to be one time funding; a smaller ask will have a higher likelihood of on-going.
* SC agreed that getting funding to be on-going and stable is worth a smaller budget

amount.

Attachments

* One Page Summary – the one pager contains the guiding principles and the priorities that were agreed to in this subgroup. We also provided a table with proposed allocations for our priority areas.
* Budget Spreadsheet – this spreadsheet shows the original proposal and a proposed $40M scenario – most, if not all of the reductions in this scenario are in the areas of the Public Health Lab, WDRS Data System, and TB.
* Slide Deck – these slides provide background information on the burden of disease in the County.

AGENDA for Tuesday, January 22 Phone Call

* Welcome
* Review Agenda and Assignment
* Walk through the attached documents
* Get agreement on allocations within the priority areas of reinforcing capacity, infrastructure, and disease investigation and response
* Next Steps
* Determine Agenda for January 29 Phone Call
* Future Agenda Topics
* Review/revised case load per disease
* Discuss who would serve as a Center of Excellence
* With disease investigation and response, determine allocation of resources in LHJs and DOH based on burden of disease, make sure there is no overlap, clarify roles and responsibilities, etc.

Let us know if you have any questions! Thanks for your attention to this important work!

JERROD DAVIS, MS
Assistant Secretary
Division of Disease Control & Health Statistics
Washington State Department of Health
Jerrod.Davis@doh.wa.gov
360-236-4204 | www.doh.wa.gov
Gender Pronouns: He/Him/His
<https://twitter.com/wadepthealth?lang=en>
<https://www.facebook.com/WADeptHealth/>
<https://www.instagram.com/wadepthealth/>
<https://www.youtube.com/channel/UCTSCpezTD0TjiiAOuJY7f5w/doh>
<https://medium.com/@WADeptHealth>

Budget Spreadsheet - FPHS CD Subgroup Assignment from FPHS Steering Committee (1-18-2019)

FPHS CD PROPOSAL	Original Propopsal ($/biennium)	$40M Proposal ($/biennium)	% Reduction from Original Proposal	NOTES
PUBLIC HEALTH LABORATORY				
Micro & ELS Lab				
Foodborne Disease	498,353	498,353		
Water Bacteriology	249,176	0		
Radiation	284,081	0		
Radiation	192,708	0		
Emerging Diseases/Issues				
Hepatitis C	498,353	498,353		
Blood lead, PFAS, opioids	284,081	0		
TB Testing (DRSS)	249,176	249,176		
Quality Assurance/Training				
QA/Training	249,176	249,176		
QA/Training	260,220	0		
Data System Interoperability				
LIMS Data System Replacement	2,530,000	400,000		Match dollars for HCA IAPD Grant
Total	**5,295,324**	**1,895,058**	**64**	
WDRS SURVEILLANCE DATA SYSTEM				
Planning, Design, and Development				
Project Manager - Manages Project Design Work	355,382	0		
Development Supervisor	177,690	0		
SME Support to New Program Development, Work with SMEs	290,570	0		
Developers	649,499	0		
Business Analyst	324,749	0		
Contractor/Vendor Costs - Conduent	700,000	0		
Contractor Costs - Johns Hopkins University	120,000	0		
Match dollars for IAPD Grant	--	400,000		Match dollars for HCA IAPD Grant
Maintenance & Operation				
Supervisor/Lead	284,081	284,081		
Informatics/CD surveillance reporting	332,166	332,166		
Deduplication and data management	467,075	467,075		
Tester	297,059	297,059		
Business Analyst	324,749	324,749		
Developer	487,124	487,124		
Release Manager	177,690	177,690		
Contractor/Vendor Costs - Conduent	240,000	240,000		
Compliance & Reporting				
LHJ Engagement Specialist	290,570	0		
Data Quality Assurance	332,166	0		
Other Investments (LHJs)				
Statewide WDRS Advisory Board (0.1 FTE for 10 LHJs)	267,014	0		
Total	**6,117,584**	**3,009,944**	**51**	
IMMUNIZATION SUPPORT				
DOH Investments				
Immunization Epi/Assessment Support to LHJs	782,500	342,000		
Improve Immunization Data Quality	867,500	420,000		Match dollars for HCA IAPD Grant
Total	**1,650,000**	**762,000**	**54**	
GENERAL COMMUNICABLE DISEASE PROPOSAL				
DOH Investments				
Emergency Response and Surge Capacity During Outbreaks	332,166	332,166		
Outbreak investigation and surveillance for Hep B	290,570	0		
Outbreak investigation and surveillance for Hep B	233,538	0		
Core Surveillance and Center of Excellence/LHJ Support, Reporting to CDC	664,331	332,166		Reduce by 1 FTE
SME in Refugee Health and Support to LHJs	407,416	407,416		
HAI - Conduct Infection Control Assessment and Response	355,382	355,382		
Hepatitis C - Conduct Epi Surveillance and Support	581,140	581,140		
Hepatitis C - Supervisor/Lead	284,081	284,081		
Hepatitis C - Technical Assistance, quality assurance for outbreaks/complicated cases	520,440	520,440		
Hepatitis C - Chronic HCV investigations	700,613	700,613		
Hepatitis C - Lab Reporting and Lab Follow Up	201,172	201,172		
Data System - Support assessment and Enhancement of CD Surveillance	332,166	0		
Data System - Supervisor	142,040	0		
Data System - Systems Coordinator	363,523	0		
LHJ Investments				

General Communicable Disease Support	8,010,420	8,010,420		
HAI Support	1,068,056	534,028		Reduce by 2 FTEs
Hepatitis C	4,005,210	4,005,210		
Total	**18,492,264**	**16,264,234**	**12**	
HIV, SYPHILIS, AND GONORRHEA SURVEILLANCE SYSTEM				
DOH Investments				
Disease Surveillance and Disease Investigations	585,495	292,748		Reduce by 1 FTE
Supervisor/Lead	284,081	284,081		
Mentors for Statewide DIS Network	520,440	260,220		Reduce by 1 FTE
Conduct Surveillance from Lab Reports and Provider Case Reports	581,140	290,570		Reduce by 1 FTE
LHJ Investments				
HIV/Gonorrhea/Syphilis Disease Intervention/Surveillance Support	6,675,350	6,675,350		
Total	**8,646,506**	**7,802,969**	**10**	
TUBERCULOSIS (TB) PREVENTION AND CONTROL				
DOH Investments				
Conduct Epi Profiles to identify high risk populations	332,166	332,166		
Informatics Focus	332,166	0		
Supervisor/Lead	284,081	284,081		
LTBI Work	260,220	0		
Support TB Elimination Efforts	201,172	0		
New WDRS Enhancement to upload all Class Bs	320,000	0		
Support for FQHCs to develop in Clinic LTBI Performance Measures	480,000	0		
Investments to LHJs				
Additional LHJ Resources for TB disease/case and contact investigation	910,000	910,000		
Treatment Costs to LHJs for a Complex Case	520,000	520,000		
LHJ Resources for Class B Evaluation & Treatment Support	900,000	900,000		
Electronic Directly Observed Therapy (eDOT) platform support for all LHJs	100,000	100,000		
Short-Course LTBI Medication Coverage Through Expanded 340B for LHJs/FQHCs	480,000	0		
Develop and Maintain a Statewide Advisory Board (0.1 FTE to 6 LHJs)	420,000	0		
Continue and Expand Demonstration Project	1,030,000	0		
Total	**6,569,805**	**3,046,247**	**54**	
REINFORCING CAPACITY TO LHJs	13,372,000	10,000,000		
Total	**13,372,000**	**10,000,000**	**25**	
GRAND TOTAL	**60,143,483**	**42,780,452**		

From: McGill, Jason (GOV)
Sent: 1/17/2019 9:56:01 AM
To: Cooper, Kelly (DOH)
Cc:
Subject: Fwd: foundational public health

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attachments\4E0C480BB7B24339_foundational public health.docx

Sent from my iPhone

Begin forwarded message:

From: "Merriman, Scott (OFM)" <scott.merriman@ofm.wa.gov>
Date: January 16, 2019 at 12:20:32 PM PST
To: "Phillips, Keith (GOV)" <Keith.Phillips@gov.wa.gov>, "McGill, Jason (GOV)" <Jason.McGill@gov.wa.gov>
Subject: FW: foundational public health

Here is the proposed language from Ro. Just waiting to hear back from Crawford. I will send it John after I hear back from him.

From: Marcus, Roselyn (OFM) <Roselyn.Marcus@OFM.WA.GOV>
Sent: Wednesday, January 16, 2019 11:50 AM
To: Crawford, Jim (OFM) <Jim.Crawford@ofm.wa.gov>
Cc: Merriman, Scott (OFM) <scott.merriman@ofm.wa.gov>
Subject: RE: foundational public health

Attached has the new section as I revised it. I also included a copy of the section showing the tracked changes. Hope this helps. Ro

From: Crawford, Jim (OFM) <Jim.Crawford@ofm.wa.gov>
Sent: Wednesday, January 16, 2019 11:39 AM
To: Marcus, Roselyn (OFM) <Roselyn.Marcus@OFM.WA.GOV>
Subject: foundational public health

From: Helmus, Lesliann E. (CDC/DDPHSS/CSELS/DHIS)
Sent: 1/17/2019 5:10:00 AM
To: Shaily Krishan,Kate Goodin,Turner, Kathy,Hoover, Michele (CDC/DDPHSS/CSELS/DHIS),Altamore, Rita A (DOH),Gillian Haney,Davidson, Sherri (CDC adph.state.al.us),MaryKate Martelon,Lichtenstein, Meredith (CDC cste.org),Keegan McCaffrey
Cc:
Subject: RE: S/I Workshop Planning call 8

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I touched base with Aaron Kite Powell on people who would be good candidates to talk about use of R and R Markdown. Keegan was his strong recommendation for someone doing interesting things and who would be a good presenter!

Still looking for more info on people who might be there to talk about data scientist role. Will try to touch base with Kate Glynn today.

Lesliann Helmus, MS, CHTS-CP
Associate Director for Surveillance
Division of Health Informatics and Surveillance
Center for Surveillance, Epidemiology and Laboratory Services
CDC Office of Public Health Scientific Services
Email lhelmus@cdc.gov | Phone 404-498-0167 | Fax 404-498-6235

From: Shaily Krishan <SKrishan@cste.org>
Sent: Tuesday, January 15, 2019 10:35 PM
To: Kate Goodin <kate.goodin@maricopa.gov>; Turner, Kathy <Kathryn.Turner@dhw.idaho.gov>; Helmus, Lesliann E. (CDC/DDPHSS/CSELS/DHIS) <lth7@cdc.gov>; Hoover, Michele (CDC/DDPHSS/CSELS/DHIS) <mlh5@cdc.gov>; Rita Altamore <Rita.Altamore@doh.wa.gov>; Gillian Haney <gillian.haney@state.ma.us>; Davidson, Sherri (CDC adph.state.al.us) <sherri.davidson@adph.state.al.us>; MaryKate Martelon <mary.kate.martelon@state.ma.us>; Lichtenstein, Meredith (CDC cste.org) <mlichtenstein@cste.org>; Keegan McCaffrey <kmccaffrey@utah.gov>
Subject: RE: S/I Workshop Planning call 8

Hi everyone,
Attached please find the brief workshop agenda with some comments & also the more detailed agenda. Below are a few action items for the planning committee:

Sessions 1 & 2: Kate & Shaily will coordinate

Session 3 (Data Marketing):
- Should we change the name of this session (Data Marketing) to something else?
- All: Provide feedback for any past CSTE AC presenters and speakers for other tracks, e.g. cross cutting, ID
- Kate follow-up:
* CA endowment chapter 4 authors
* Review presentation from CDC presenters from EIS- Eric Pevzner and Michael King (sent by Lesliann), determine if we should invite them?
* FL Flu report presenters
* NCDPH PIO
* Presenter to talk about use of syndromic data
* A. Kite Powell (CDC) for use of R dashboards (leveraging open source, low cost tools)

Session 4 (Workforce):

- Meredith: Follow up about ASTHO Informatics Director's Peer Network (IDPN), Kathy can help if needed
- Lesliann: Kate Glynn/ someone from CDC to cover the concept of “data scientist”
- Shaily: Follow up about CSTE workforce activities (AITT, Workforce Informatics Incubator recommendations, how can the workshop can be leveraged to provide feedback to CSTE WF to plan training to increase capacity)
- Keegan: Follow up with Informatics staff at UT for workforce skills needed, gaps in data scientist role

General:
Funding is available for invited speakers or can be used for contracts to develop products/ reports from the workshop- please let Shaily know if you have any ideas/ suggestions.

Our next planning call will be on Tuesday, 1/29, 3-4 pm ET. Thank you!
Shaily

From: Shaily Krishan
Sent: Monday, January 14, 2019 10:34 AM
To: 'Kate Goodin (PHS)' <Kate.Goodin@Maricopa.gov>; 'Turner, Kathy' <Kathryn.Turner@dhw.idaho.gov>; 'Helmus, Lesliann E. (CDC/DDPHSS/CSELS/DHIS)' <lth7@cdc.gov>; Hoover, Michele (CDC/OPHSS/CSELS) (mlh5@cdc.gov) <mlh5@cdc.gov>; Rita Altamore (Rita.Altamore@doh.wa.gov) <Rita.Altamore@doh.wa.gov>; 'Haney, Gillian (DPH)' <gillian.haney@state.ma.us>; 'Sherri.Davidson@adph.state.al.us' <Sherri.Davidson@adph.state.al.us>; 'Martelon, MaryKate (DPH)' <mary.kate.martelon@state.ma.us>; Meredith Lichtenstein <mlichtenstein@cste.org>; 'Keegan McCaffrey' <kmccaffrey@utah.gov>
Subject: RE: S/I Workshop Planning call 8
Importance: High

Good morning!
This is a friendly reminder for our workshop planning call Today, 1/14 at 1pm ET. We hope you can all join the call today, as we will talk about workshop speakers, and specifically discuss some additional funding available to us to reach out to speakers/trainers/ facilitators. I have attached the re-formatted agenda with time slots & the detailed agenda. Talk to you soon!
Thanks,
Shaily

-----Original Appointment-----
From: Shaily Krishan
Sent: Friday, December 21, 2018 10:59 AM
To: Shaily Krishan; Kate Goodin (PHS); Turner, Kathy; Helmus, Lesliann E. (CDC/DDPHSS/CSELS/DHIS); Hoover, Michele (CDC/OPHSS/CSELS) (mlh5@cdc.gov); Rita Altamore (Rita.Altamore@doh.wa.gov); Haney, Gillian (DPH); Sherri Davidson; MaryKate Martelon; Meredith Lichtenstein; 'Keegan McCaffrey'
Subject: S/I Workshop Planning call 8
When: Monday, January 14, 2019 1:00 PM-2:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Phone Booth 4

Hi everyone,

Please use the call information below for the S/I workshop planning call on 1/14, 1-2 pm ET. I’ll send an agenda closer to the call:

CALL INFORMATION:
Call in number (Toll-Free): 1-877-668-4490

Access code: 793 842 512
Link: https://cste.webex.com/meet/skrishan

Thanks!
Shaily

Shaily Krishan, MPH
Program Analyst III
Surveillance and Informatics Program

Council of State and Territorial Epidemiologists
"Using the power of epidemiology to improve the public's health"
CSTE.org • Membership • Facebook • Twitter • Instagram
2635 Century Parkway NE, Suite 700, Atlanta, GA 30345
Tel: 770.458.3811 | Fax: 770.458.8516

From: Flake, Marie D (DOH)
Sent: 1/15/2019 4:14:39 PM
To: Black, Ryan (DOH),Bodden, Jaime (DOHi),Burkland, Anne (DOHi),Calder, Allegra (DOHi),Courogen, Maria (DOH),Davis, Michelle (DOH),Debolt, Meghan (DOHi),Delahunt, Regina (DOHi),Dzedzy, Ed (DOHi),Flake, Marie D (DOH),Goelz, Mary (DOHi),Halvorson, Clark R (DOH),Joyner, Pama (DOH),Ketchel, Jeff (DOHi),Kirkpatrick, Vicki (DOHi),Lindquist, Scott W (DOH),Melnick, Alan (DOHi),Miller, Angi (DOH),Rohr Tran, Holly (DOHi),Schanz, Matt (DOHi),Schuler, Christopher (DOHi),Tammy Axlund ,Turner, Susan (DOHi),Wilson, Lyndia (DOHi),Windom, David (DOHi),Wolfe, Roxanne (DOHi),Worsham, Dennis (DOHi),York, Danette (DOHi)
Cc:
Subject: FPHS TWG Meeting 1/18/19 - proposed language for lab

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attachments\4EAD0A637F774873_image001.png
attachments\82EEC66CC5B147C2_image019.png
attachments\3D473ED466784EFD_image009.png
attachments\75DB3534AB2F4745_image017.png
attachments\8E32B8063A794120_image005.png
attachments\F850B64DD3A54001_image003.png

TWG,
I'm share this with Ed's permissions. He has a proposal for your consideration.

I was reviewing the definitions and I struggled with the definition around lab sampling, so I created my own definition that sounds better to me. How about this:

"Utilizing scientific methods and best practices, when indicated, to collect environmental samples and human specimens for laboratory analysis to confirm or rule out disease presence. This includes packaging in conformance with DOT and USPS requirements and shipping to a certified laboratories for analysis."

Perhaps this would replace the definitions identified in:

Page 32, G (CD) 4 (Investigation) d – adding efforts to collect, package, ship and test CD samples
Page 41 & 42, I (EH) 3 (Investigations) – adding efforts to collect, package, ship and test EH samples

Just a thought

Ed Dzedzy

Lincoln County

From: Flake, Marie D (DOH) [mailto:marie.flake@doh.wa.gov]
Sent: Friday, January 11, 2019 1:57 PM
To: Black, Ryan (DOH) <Ryan.Black@DOH.WA.GOV>; Bodden, Jaime (DOHi) <Jbodden@wsac.org>; Burkland, Anne (DOHi) <Anne.Burkland@kingcounty.gov>; Calder, Allegra (DOHi) <allegra@berkconsulting.com>; Courogen, Maria (DOH) <Maria.Courogen@DOH.WA.GOV>; Davis, Michelle (DOH) <Michelle.Davis@sboh.wa.gov>; Debolt, Meghan (DOHi) <mdebolt@co.walla-walla.wa.us>; Delahunt, Regina (DOHi) <rdelahun@whatcomcounty.us>; Ed Dzedzy <edzedzy@co.lincoln.wa.us>; Flake, Marie D (DOH) <marie.flake@doh.wa.gov>; Goelz, Mary (DOHi) <mgoelz@co.pacific.wa.us>; Halvorson, Clark R (DOH) <Clark.Halvorson@DOH.WA.GOV>; Joyner, Pama (DOH) <Pama.Joyner@DOH.WA.GOV>; Ketchel, Jeff (DOHi) <jketchel@snohd.org>; Kirkpatrick, Vicki (DOHi) <VKirkpatrick@co.jefferson.wa.us>; Lindquist, Scott W (DOH) <scott.lindquist@doh.wa.gov>; Melnick, Alan (DOHi) <alan.melnick@clark.wa.gov>; Miller, Angi (DOH) <Angi.Miller@DOH.WA.GOV>; Rohr Tran, Holly (DOHi) <Holly.RohrTran@kingcounty.gov>; Schanz, Matt (DOHi) <mschanz@netchd.org>; Schuler, Christopher (DOHi) <cschuler@tpchd.org>; Tammy Axlund <taxlund@co.whatcom.wa.us>; Turner, Susan (DOHi) <Susan.Turner@kitsappublichealth.org>; Wilson, Lyndia (DOHi) <Lwilson@srhd.org>; Windom, David (DOHi) <DWindom@co.mason.wa.us>; Wolfe, Roxanne (DOHi) <Roxanne.wolfe@clark.wa.gov>; Worsham, Dennis (DOHi) <Dennis.worsham@kingcounty.gov>; York, Danette (DOHi) <danette.york@lewiscountywa.gov>
Subject: FPHS TWG Meeting 1/18/19

Dear TWG,
Happy New Year. We scheduled to meet next Friday, 1/18, 1:30-3pm to finalize the functional definitions – for this moment in time. Connection info is below and should be on your calendar.

Attached is the final draft version we have used for the past year with the tweaks this group settled on in December shown using track changes. I also incorporated the comment receive by e-mail from Susan after that meeting. Below is a summary of the proposed changes. Please review in advance so we can complete this task during the meeting. If you are not able to participate in the meeting, please send your comments in advance. Thank you.

Connection
* Webinar: https://global.gotomeeting.com/join/990414661
* Audio by phone: (872) 240-3212 / Access Code: 990-414-661
Summary of Proposed Changes to Functional Definitions – for discussion/approval by TWG on 1/18/19

* Page 29, G (CD) 1 (Data) – b (Immunization Information System) – Centralized Activity; c, d, f – adding effort for data input, quality, educating providers.

* Page 31, G (CD) 3 (Immunizations) & b – adding effort for promoting IIS and data input, quality, educating providers.

* Page 32, G (CD) 4 (Investigation) d – adding efforts to collect, package, ship and test CD samples; e – receive case reports from providers, labs and other reporters.

* Page 34, G (CD) 5 (PHL) – Centralized Activity with support from PHSKC

* Page 41 & 42, I (EH) 3 (Investigations) – adding efforts to collect, package, ship and test EH samples

* Page 47, J (MCH) 3 (Newborn screening) – Centralized Activity

* Page 50, K (Access) 3 (Licensing) – Centralized Activity

* Page 52, L (VR) 1 (Data system) – Centralized Activity

Talk with you next week.

Marie

Marie Flake
Special Projects
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<https://twitter.com/wadepthealth?lang=en>
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<https://www.instagram.com/wadepthealth/>
<https://www.youtube.com/channel/UCTSCpezTD0TjiiAOuJY7f5w/doh>
<https://medium.com/@WADeptHealth>

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<https://twitter.com/wadepthealth?lang=en>
<https://www.facebook.com/WADeptHealth/>
<https://www.instagram.com/wadepthealth/>
<https://www.youtube.com/channel/UCTSCpezTD0TjiiAOuJY7f5w/doh>
<https://medium.com/@WADeptHealth>

From: Close, Natasha (DOH)
Sent: 1/17/2019 2:53:00 PM
To: English, Roseanne (CDC/DDPHSS/CSELS/DHIS)
Cc:
Subject: RE: TC Forum topics posted


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attachments\91120C67C7DE45F6_image002.jpg

Excellent. Yes, it's not intuitive. Just remember, that means you will see any new posts to those threads, but no resulting chatter within (not that there is much).

From: English, Roseanne (CDC/DDPHSS/CSELS/DHIS) [mailto:rxe1@cdc.gov]
Sent: Thursday, January 17, 2019 2:52 PM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Subject: RE: TC Forum topics posted

Thank you again. I think I know what was wrong.

I thought the "Green check box" suggested I was already subscribed. But I was not. You have to click on it and then it turns to a red X with "unsubscribe" as an option. I have gone ahead and subscribed for General and Technical Issues.

So I think I should start seeing emails.

Thank you so much!!

Roseanne

Roseanne English

Analytic Data Management Lead
Surveillance and Data Science Team
Division of Health Informatics and Surveillance
Center for Surveillance, Epidemiology, and Laboratory Services
CDC Office of Public Health Scientific Services
1600 Clifton Road, Mail Stop: E-97, Atlanta, GA 30333
Email: rxe1@cdc.gov | Phone 404-498-2468 | Mobile: 404-580-4055

From: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Sent: Wednesday, January 16, 2019 2:53 PM
To: English, Roseanne (CDC/DDPHSS/CSELS/DHIS) <rxe1@cdc.gov>
Subject: RE: TC Forum topics posted

See if this helps: https://vimeo.com/album/5083819/video/262846169

When you're in a forum, click on a forum thread.

On this page, you can subscribe to instant updates or a digest of new *topics* posted in

this thread. You will ONLY see if someone posts a new topic posted by doing this.

If you want to see all postings under a topic (e.g., replies to topic), you will have to click on the topic of interest and subscribe to it.

Unfortunately there is no way to tell the website you want to know about all activity on a specific forum…you have to subscribe to all threads (to get notices when a new topic is posted) AND to each topic. PAINFUL!

From: English, Roseanne (CDC/DDPHSS/CSELS/DHIS) [mailto:rxe1@cdc.gov]
Sent: Tuesday, January 15, 2019 12:56 PM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Subject: RE: TC Forum topics posted

Thanks. I feel like an idiot but I can't figure out how to verify I am subscribed. Do you know? I never get any emails when posts are made to the DQ Committee forum so I must be doing something wrong!

Roseanne

Roseanne English

Analytic Data Management Lead
Surveillance and Data Science Team
Division of Health Informatics and Surveillance
Center for Surveillance, Epidemiology, and Laboratory Services
CDC Office of Public Health Scientific Services
1600 Clifton Road, Mail Stop: E-97, Atlanta, GA 30333
Email: rxe1@cdc.gov | Phone 404-498-2468 | Mobile: 404-580-4055

From: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Sent: Tuesday, January 15, 2019 11:02 AM
To: Hoferka, Stacey (CDC illinois.gov) <stacey.hoferka@illinois.gov>; DAVID.SWENSON@dhhs.nh.gov; Daniel.Bedford@dhs.wisconsin.gov; Wiedeman, Caleb (CDC tn.gov) <caleb.wiedeman@tn.gov>; Coletta, Michael A. (CDC/DDPHSS/CSELS/DHIS) <mac0@cdc.gov>; English, Roseanne (CDC/DDPHSS/CSELS/DHIS) <rxe1@cdc.gov>; Brown, Lindsay R. (CDC/DDPHSS/CSELS/DHIS) (CTR) <imb2@cdc.gov>; Powell, Ariel (CDC/DDPHSS/CSELS/DHIS) (CTR) <kyx6@cdc.gov>; Mishra, Kristina (CDC/DDPHSS/CSELS/DHIS) (CTR) <xyx7@cdc.gov>; ctong@syndromic.org
Subject: TC Forum topics posted

Just wanted to let you all know I was finally able to post updates to the TC forum about our two "issues" we discussed at the meeting. If you have, subscribe to the thread to see any comments. I'll try to send a message to the group letting them know and provide links to the postings. Cat - when you think the slides/recording will be posted? I refer to them in my posts. Thanks!

Natasha Close, MPH
Suveillance Epidemiologist
Division of Disease Control and Health Statistics
Washington State Department of Health
natasha.close@doh.wa.gov

206-430-0617 | www.doh.wa.gov
<https://twitter.com/wadepthealth?lang=en>
<https://www.facebook.com/WADeptHealth/>
<https://www.instagram.com/wadepthealth/>
<https://www.youtube.com/channel/UCTSCpezTD0TjiiAOuJY7f5w/doh>
<https://medium.com/@WADeptHealth>

_____
From: Bryan, Zandt (DOH)
Sent: 1/16/2019 11:54:00 AM
To: Nguyen, Dana,Czapla, Monica
Subject: RE: quick budget question - need response by or before 3pm


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attachments\5566254C375F4512_image002.jpg


attachments\58A61E9DB6D44A4A_image003.jpg


attachments\A311BACBFA784958_image004.jpg

Great question – I wasn't clear enough, as I was moving quickly and forgot to qualify that. Thank you.

I'm talking about non-SSP staff – DIS or surveillance or program manager.

From: Nguyen, Dana [mailto:Dana.Nguyen@clark.wa.gov]
Sent: Wednesday, January 16, 2019 11:52 AM
To: Bryan, Zandt (DOH); Czapla, Monica
Cc: Miller, Katrina (DOH)
Subject: RE: quick budget question - need response by or before 3pm

Zandt,
Would you be able to provide the specific items in the Scope of Work fall under your specific contract? I believe that you are referring to all HIV/STD line items, correct? And Sarah has all SSP items?

Dana C. Nguyen BSN, RN, CIC
Infection Control Practitioner, Program Coordinator II
COMMUNICABLE DISEASE
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PO Box 9825 | Vancouver, WA 98666-8825
564.397.2000 ext 7272 (note: our office area code has changed)
360.524.1167 cell
564.397.8080 fax (note: our office area code has changed)
dana.nguyen@clark.wa.gov

<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>
<https://twitter.com/ClarkCoWA> <https://www.youtube.com/user/ClarkCoWa/>

From: Bryan, Zandt (DOH) [mailto:Zandt.Bryan@DOH.WA.GOV]
Sent: Wednesday, January 16, 2019 11:05 AM
To: Czapla, Monica; Nguyen, Dana
Cc: Miller, Katrina (DOH)
Subject: quick budget question - need response by or before 3pm
Importance: High

Good morning, Monica, Dana:

About how many FTE in your program would you say the funds in the DOH contract I manage with you currently support in your program?

Thanks for any rapid response you can provide.
-z.

Zandt Bryan (pronouns: he/him)
Infectious Disease Field Services Coordinator
Washington Department of Health
PO Box 47840
Olympia, WA 98504
Zandt.Bryan@doh.wa.gov
T: (360) 890-5816
F: (360) 236-3470

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_____
From: Loschen, Wayne A.
Sent: 1/18/2019 10:57:46 AM
To: Close, Natasha (DOH),Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS)
Subject: RE: All Traffic Related v2 CCDD Category

So,

Of the 5 CCDD Categories, I am updating them in this order:

Asthma
Food Poisoning
Measles
Pneumonia
Traffic

It is currently finished the first 2, and is on Measles – Dec 1999 (it starts from 1900 and works its way to today)

It's tough to project though, because the Pneumonia and Traffic ones will be slower (they're more complex)

Wayne

Wayne Loschen
Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

From: Close, Natasha (DOH) <Natasha.Close@doh.wa.gov>
Sent: Friday, January 18, 2019 1:53 PM
To: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Cc: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Subject: Re: All Traffic Related v2 CCDD Category

Ah, ok. So maybe not until Tuesday...

We are working on a measles outbreak so weekends/holidays are not quite as meaningful at the moment. :)
Natasha Close, MPH
Suveillance Epidemiologist
Division of Disease Control and Health Statistics
Washington State Department of Health
natasha.close@doh.wa.gov
206-430-0617 | www.doh.wa.gov
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<https://www.instagram.com/wadepthealth/>
<https://www.youtube.com/channel/UCTSCpezTD0TjiiAOuJY7f5w/doh>
<https://medium.com/@WADeptHealth>

On Jan 18, 2019, at 10:49 AM, Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS)

<lyv8@cdc.gov> wrote:
Yeah, and remember that Monday is a holiday, at least for us, but if Wayne is working and it's done perhaps he'll kick off the last step to re-build the cubes? After that it will be ready to use.

Aaron

From: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>
Sent: Friday, January 18, 2019 1:47 PM
To: Close, Natasha (CDC doh.wa.gov) <natasha.close@doh.wa.gov>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Correct. It is running now.

I don't know if it will finish by Monday (we added 5 new categories), but it will be running all weekend for sure.

Wayne

Wayne Loschen
Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

From: Close, Natasha (DOH) <Natasha.Close@doh.wa.gov>
Sent: Friday, January 18, 2019 1:45 PM
To: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

I see you've put in the definition and am patiently waiting to use it as I assume the tables are building. Should I expect this process to complete by Monday?

Thanks!
natasha

From: Close, Natasha (DOH)
Sent: Thursday, January 17, 2019 11:32 AM
To: 'Loschen, Wayne A.' <Wayne.Loschen@jhuapl.edu>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Yay! So excited!!!!! Thanks!

Natasha

From: Loschen, Wayne A. [mailto:Wayne.Loschen@jhuapl.edu]
Sent: Thursday, January 17, 2019 11:27 AM
To: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>; Kite Powell, Aaron

(CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Got it – thanks.

Wayne

Wayne Loschen
Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

From: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Sent: Thursday, January 17, 2019 2:05 PM
To: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>
Cc: Close, Natasha (CDC doh.wa.gov) <natasha.close@doh.wa.gov>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: All Traffic Related v2 CCDD Category

Wayne,

Please find Natasha's All Traffic Related v2 in the attached document. Please let me know if you have any questions about it.

Thank you!
Zach

ZACHARY STEIN, MPH
Syndromic Surveillance Analyst
ICF Contractor, BioSense Platform
Center for Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention (CDC)
316.371.3945
oru8@cdc.gov

From: Miller, Katrina (DOH)
Sent: 1/17/2019 1:31:18 PM
To: Nguyen, Dana
Subject: FW: Training checklist

attachments\0EE6377ACEBA4953_ODS DIIS 6 month training checklist.docx

attachments\F0D0DB8F4EBC48EB_ODS DIIS 30 Day training checklist.docx

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attachments\8826D15EA5634FD5_ODS DIIS 90 Day training checklist.docx

attachments\3540405134444FFF_ODS DIIS 1 year training checklist.docx

Hey Dana,
I reached out to my former program in NV to see if they were willing to share their DIS training checklist and they gave me essentially their training program for all DIS staff through their first year. Please see the attached documents and let me know if you need any help going through them. :-)

Katrina Miller
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Washington State Department of Health
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Tumwater, WA 98504-7840
katrina.miller@doh.wa.gov
360-236-3425 (office)| www.doh.wa.gov
360-890-5886 (cell)
360-236-3470 (fax)
<https://www.doh.wa.gov/Newsroom/SocialMedia>

From: Candyce White [mailto:whitec@SNHD.ORG]
Sent: Thursday, January 17, 2019 1:08 PM
To: Miller, Katrina (DOH) <katrina.miller@doh.wa.gov>
Subject: Training checklist

Hey girl!

Your charm worked! Here ya go! Let me know if this is what you need or if you need something else

Candyce White
Sr. DIIS
Southern NV Health District
Office of Disease Surveillance
(702)759-0728 whitec@snhd.org

From: Bryan, Zandt (DOH)
Sent: 1/16/2019 5:01:00 PM
To: Mobley, Kayla
Cc:
Subject: RE: quick budget question - need response by or before 3pm


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attachments\9B5CFB45A0324B07_image008.jpg


attachments\9E9939BC6CA64AF5_image005.jpg


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attachments\9D2DB6EC3EE34D93_image003.jpg


attachments\2EC0EDB5D9C44279_image004.jpg


attachments\74586AB8E594461C_image007.jpg

Many thanks for the rapid response.

From: Mobley, Kayla [mailto:Kayla.Mobley@clark.wa.gov]
Sent: Wednesday, January 16, 2019 4:25 PM
To: Bryan, Zandt (DOH)
Cc: Nguyen, Dana
Subject: RE: quick budget question - need response by or before 3pm

Sorry Zandt; just realized I calculated based on a full calendar year, not 6 months. Should be about 1.6 FTE.

From: Mobley, Kayla
Sent: Wednesday, January 16, 2019 4:21 PM
To: 'Bryan, Zandt (DOH)'
Cc: Nguyen, Dana
Subject: RE: quick budget question - need response by or before 3pm

Zandt,

I would estimate that the grants (excluding SSP) support approximately .8 FTE

Thank you,
Kayla

From: Bryan, Zandt (DOH) [mailto:Zandt.Bryan@DOH.WA.GOV]
Sent: Wednesday, January 16, 2019 1:08 PM
To: Mobley, Kayla
Cc: Nguyen, Dana
Subject: RE: quick budget question - need response by or before 3pm

Hi Kayla: Thanks for helping us. To answer your questions:

1. Upcoming Jan-Jun 2019 cycle is fine

a. Net FTE total
2. You are correct that it's all tasks except SSP.

Thanks –
z.

From: Mobley, Kayla [mailto:Kayla.Mobley@clark.wa.gov]
Sent: Wednesday, January 16, 2019 12:53 PM
To: Bryan, Zandt (DOH)
Cc: Nguyen, Dana
Subject: RE: quick budget question - need response by or before 3pm

Hey there, Zandt:

I'm the math-y type person here in Public Health, and I'm trying to help Dana get you the answers you need. I have a couple of questions:

1. Are you looking for total FTE funded by your portion of the grant the past cycle, or the upcoming Jan-Jun 2019 cycle?
a. Do you need the FTE total by employee, or just a net FTE total?
2. Are your portions described in the SOW as specific tasks? I'm assuming it's all tasks except SSP, but want to make sure.
a. Previous cycle tasks 2018:
TASK: PREV-1a State HIV Prev TASK: PREV-1b AAPPS TASK: PREV-1c ADAP RebateTASK: SSP-1 State HIV Prev

b. Jan-Jun 2019 tasks:
TASK: SSP TASK: Clark County Mobile Syringe TASK: Safer Syringe Disposal TASK: HIV/STD Prev - State HIV Prevention TASK: HIV/STD Prev - HIV Prevention (Cat A) TASK: HIV Positive (+) Prevention Activities

Thank you!
Kayla
<https://www.clark.wa.gov/>

Kayla Mobley
Senior Financial Management Analyst
PUBLIC HEALTH

564.397.8235

<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>
<https://twitter.com/ClarkCoWA> <https://www.youtube.com/user/ClarkCoWa/>

From: Bryan, Zandt (DOH) [mailto:Zandt.Bryan@DOH.WA.GOV]
Sent: Wednesday, January 16, 2019 11:56 AM
To: Nguyen, Dana; Czapla, Monica
Cc: Miller, Katrina (DOH)
Subject: RE: quick budget question - need response by or before 3pm

Great question – I wasn't clear enough, as I was moving quickly and forgot to qualify that. Thank you.

I'm talking about non-SSP staff – DIS or surveillance or program manager.

From: Nguyen, Dana [mailto:Dana.Nguyen@clark.wa.gov]
Sent: Wednesday, January 16, 2019 11:52 AM
To: Bryan, Zandt (DOH); Czapla, Monica
Cc: Miller, Katrina (DOH)
Subject: RE: quick budget question - need response by or before 3pm

Zandt,
Would you be able to provide the specific items in the Scope of Work fall under your specific contract? I believe that you are referring to all HIV/STD line items, correct? And Sarah has all SSP items?

Dana C. Nguyen BSN, RN, CIC
Infection Control Practitioner, Program Coordinator II
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dana.nguyen@clark.wa.gov

<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>
<https://twitter.com/ClarkCoWA> <https://www.youtube.com/user/ClarkCoWa/>

From: Bryan, Zandt (DOH) [mailto:Zandt.Bryan@DOH.WA.GOV]
Sent: Wednesday, January 16, 2019 11:05 AM
To: Czapla, Monica; Nguyen, Dana
Cc: Miller, Katrina (DOH)
Subject: quick budget question - need response by or before 3pm
Importance: High

Good morning, Monica, Dana:

About how many FTE in your program would you say the funds in the DOH contract I manage with you currently support in your program?

Thanks for any rapid response you can provide.
-z.

Zandt Bryan (pronouns: he/him)
Infectious Disease Field Services Coordinator
Washington Department of Health
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Olympia, WA 98504
Zandt.Bryan@doh.wa.gov
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_____
From: Kennedy, Susan
Sent: 1/18/2019 8:59:38 AM
To: Kennedy, Susan
Subject: Medicaid PrEP Meeting - Agenda and Supporting Materials for Your Review

attachments\520A92B2365E41CD_PrEP In-Person Meeting Agenda_Final.pdf

attachments\B215F2EADF194D1F_EnhancingProviderPatientEngagemen_PRDTOOL_NAMETOOLONG.pdf

attachments\D7E07D739B6C470D_LeveragingFinancingCoverageMedica_PRDTOOL_NAMETOOLONG.pdf

Dear Medicaid PrEP Project Meeting Attendees –

We are looking forward to seeing you at our Medicaid Strategies to Implement Comprehensive Pre-exposure Prophylaxis (PrEP) Clinical Care Services Project meeting next week, January 24-25, in Atlanta. Attached, please find the meeting agenda and supporting materials.

In preparation for the meeting, we request that you review the attached AcademyHealth commissioned White Papers that were specifically prepared for the meeting. As you do, please consider the Medicaid policy levers they address to support PrEP clinical care services, and how this relates to and supports your own efforts as well as that of your collaborative colleagues involved in delivering PrEP clinical care services. Referencing the white papers, we also ask that you consider the meeting objectives, outlined below, in the context of your state Medicaid policy environment and current collaborative relationships with related state agencies and health plans.

The meeting will serve to engage representatives like yourself from select state Medicaid and public health agencies, as well as other important stakeholders, to explore issues affecting Medicaid beneficiaries' access to HIV pre-exposure prophylaxis (PrEP) clinical care services. Specifically, attendees will:
1. Discuss the current state of PrEP clinical care access and delivery within Medicaid,
2. Explore ways to improve the availability, accessibility, and quality of PrEP clinical care, and/or
3. Identify approaches for maintaining and extending quality PrEP clinical services amidst scale-up.

Additionally, I wish to remind you that the meeting will be held at the Sheraton Atlanta Hotel (165 Courtland Street NE), where those traveling from out-of-state will also be staying. An email with your hotel information, including confirmation number, will be arriving shortly. Attire for the meeting is business casual.

Final Note: Due to the government shut-down, the Atlanta Airport, Hartsfield is experiencing extreme security delays. I encourage you to view your departure times on Friday, January 25 and plan your arrival back to the airport accordingly to avoid missing your flight.

If you have any questions, please contact me or Rachel Ruback at rachel.ruback@academyhealth.org.

Kindly,
Susan

SUSAN KENNEDY, MPP, MSW
Senior Manager, State Health Policy
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AcademyHealth

Medicaid Strategies to Implement Comprehensive Pre-exposure Prophylaxis (PrEP) Clinical Care Services Project

January 24-25, 2019

Sheraton Atlanta Hotel, Valdosta Room
165 Courtland Street NE, Atlanta, Georgia

Meeting Objective: *This meeting will engage representatives from select state Medicaid and public health agencies, as well as other important stakeholders, to explore issues affecting Medicaid beneficiaries' access to HIV pre-exposure prophylaxis (PrEP) clinical care services. Using findings from two Academy-Health commissioned papers as their starting point, attendees will:*

- *Discuss the current state of PrEP clinical care access and delivery within Medicaid.*
- *Explore ways to improve the availability, accessibility, and quality of PrEP clinical care.*
- *Identify approaches for maintaining and extending quality PrEP clinical services amidst scale-up.*

The meeting allows for ample networking opportunities and discussion among state peers.

Agenda

Thursday, January 24

8:00 – 8:45 am **Registration Check-In, Informal Networking Breakfast**

8:45 – 9:00 am **Welcome and Context**
Susan Kennedy, MPP, MSW, AcademyHealth
Raul Romaguera, DMD, MPH, Deputy Director, Division of STD Prevention Centers for Disease Control and Prevention

9:00 – 9:05 am **Project and Meeting Purpose**
Susan Kennedy, MPP, MSW, AcademyHealth

9:05 – 9:45 am **Participant Introductions and Agenda Overview**
Margaret Trinity, MBA, Bailit Health

9:45 – 10:30 am **Keynote: At the Intersection of Health Care and Public Health**
Reed V. Tuckson, MD, FACP
Moderator: William Pearson, PhD, MHA, Centers for Disease Control and Prevention

Dr. Tuckson will situate issues affecting Medicaid beneficiary access to PrEP clinical care within the context of our rapidly evolving health care delivery system, and the health care system dynamics of quality and cost. He will then

share lessons and experiences learned over decades of leadership within the health care system – lessons aimed at enhancing the success of PrEP clinical care in today's rapidly changing health care delivery system. He will discuss the tools and infrastructure that both public health and medical care stakeholders have at their disposal to improve the uptake and delivery of PrEP clinical care.

10:30 – 11:00 am **Networking Break**

11:00 – 12:30 pm **Design and Implementation of PrEP Benefits and Coverage**
Naomi Seiler, JD, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

Ms. Seiler will share key findings from her recent examination of PrEP-related Medicaid benefits and financing options (see White Paper #1). Following initial reactions from a panel of discussants, the audience will explore the applicability and relevance of Dr. Seiler's findings within the context of their own state/institutional personal experiences.
Discussants:
Doug Fish, MD, Medicaid Medical Director, New York Department of Health
Jim Hellinger, MD, Medical Director, Neighborhood Health Plan (MA)

Facilitator: Margaret Trinity

12:30 – 1:30 pm **Lunch**

1:30 – 3:00 pm **Delivering High Quality PrEP Care: Provider Engagement and Support**
Naomi Seiler, JD, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

Ms. Seiler will share key findings from her recent examination of opportunities to educate and engage Medicaid providers around PrEP clinical care (see White Paper #2). Following initial reactions from a panel of discussants, the audience will explore how they might operationalize or otherwise apply Dr. Seiler's results within their own programs and practice settings.
Discussants:
Philip Chan, MD, MS, Medical Consultant, DSTDP, CDC; Associate Professor, Brown University
DeAnn Gruber, PhD, Louisiana Department of Public Health
Facilitator: Margaret Trinity

3:00 – 3:30 pm **Networking Break**

3:30 – 4:45 pm **State Showcase: Lessons from Michigan and New York**

During this session, two states will present their experiences implementing and/or expanding PrEP access and use among Medicaid-beneficiaries—particularly those covered under managed care arrangements. Participants will hear both state and MCO perspectives on challenges and solutions related to PrEP delivery within Medicaid managed care.

Panelists:
Michigan
David Neff, MD, Chief Medical Director, Michigan Department of Health & Human Services (MI DHHS)
Katie Macomber, MPH, Director, Division of HIV/STD Programs, MI DHHS
Dave Rzeszutko, MD, Medical Director, Priority Health

New York
Doug Fish, MD, Medicaid Medical Director, New York Department of Health
Lyn Stevens, Deputy Director, Office of the Medical Director, NYS DOH AIDS Institute
Doug Wirth, MSW, CEO, Amida Care

Responder:
Mike Wofford, PharmD, Chief of Pharmacy Policy, Medi-Cal Pharmacy Benefits Division, California Department of Health Care Services

Facilitator: Susan Kennedy

4:45 – 5:00 pm **Announcements and Day One Adjournment**

Friday, January 25

8:00 – 8:30 am **Networking Breakfast**

Join the day's speakers for breakfast and an informal networking opportunity.

8:30 – 9:30 am **Delivering High Quality PrEP Care: Patient Engagement**

Naomi Seiler, JD, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

Ms. Seiler will share key findings from her recent examination of opportunities to improve Medicaid beneficiary access and engagement in patient-centered PrEP clinical care (see White Paper #2). Following initial reactions from a panel of discussants, the audience will explore ways that Medicaid and public health—alone or in partnership—can better address beneficiaries' specific needs and barriers to accessing care.

Discussants:
Sean Bland, Georgetown University
Elizabeth Hacker, MPH, PrEP Coordinator, Detroit Public Health STD Clinic
Pedro Alonso Serrano, MPH, Hektoen Institute of Medicine

Facilitator: Margaret Trinity

9:30 – 10:45 am **Pulling It All together – Priorities and Pathways for State Action**

In this prioritization exercise, pairs of state teams will huddle to problem solve, identify and document the following:

- Three priority actions for your state—this will vary based on each state's "starting point."
- Tasks associated with each action item, and identify facilitators as appropriate.
- Ways in which public health, Medicaid and MCOs can work collaboratively to implement work plan.
- Guidance, resources, and technical assistance needs.

10:45 – 11:00 am **Break**

11:00 – 12:00 pm **Prioritization Activity Report Out**

States briefly share priority actions and collaborative opportunities identified during their team huddles. Participants will provide input to one another's action items and work plans.

Facilitator: Susan Kennedy

12:00 – 12:15 pm **Closing Remarks and Adjournment**

Susan Kennedy, MPP, MSW, AcademyHealth

Enhancing Provider and Patient Engagement and Education: Medicaid Strategies to Deliver PrEP Intervention Services

Prepared for the CDC, ChangeLab and AcademyHealth as part of the Medicaid Strategies to Implement Comprehensive PrEP Intervention Services project

Naomi Seiler, JD

January 2019

Table of Contents

Thank you to all of the experts who participated in interviews for this project, as well as to those who generously reviewed a draft: Jeffrey Crowley at the O'Neill Institute at Georgetown Law; and Pedro Alonso Serrano, Hektoen Institute. Any mistakes or omissions are the author's.

Funding for this paper was made possible by the Centers for Disease Control and Prevention and ChangeLab Solutions under Cooperative Agreement NU38OT000141. The findings and conclusions of this paper are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Introduction

Pre-exposure prophylaxis, or PrEP, is a highly effective HIV prevention intervention that is dramatically underused, with one recent analysis suggesting that fewer than 1 in 10 people with indications for PrEP in the U.S. are receiving it.[1] Use of PrEP is disproportionately low among African American and Latinx people, as well as lower-income populations.[2,3,4] Between 2015 and 2016, an estimated 1.14 million Americans were eligible for PrEP, but only 90,000 prescriptions for Truvada for PrEP were filled. What's more, utilization showed significant racial and ethnic disparities in use. Though African Americans represent over 45 percent of people with indications for PrEP use in the U.S.,[5] they accounted for only 11.2 percent of PrEP users in 2016.[6] Regional disparities in the HIV epidemic are reflected in lower PrEP use as well: the South accounted for over half of new HIV diagnoses in 2016, but fewer than 30 percent of PrEP users.[7]

Among those who do use PrEP, some may not be receiving the Centers for Disease Control and Prevention's (CDC) full set of recommended PrEP clinical services – such as HIV screening before initiation and quarterly, multisite sexually transmitted infection (STI) screenings. A recent study of providers in San Francisco Public Health Primary Care Clinics found that when initiating PrEP, providers failed to order HIV tests in nearly a quarter of patients, and failed to order STI tests in nearly a fifth of patients.[8] Once patients were on PrEP, providers ordered STI testing in only 72 percent of follow-up intervals.[9]

As part of its work to address these challenges, the CDC is supporting a project, led by AcademyHealth and ChangeLab, to identify ways to improve delivery of PrEP medication and clinical services to the Medicaid population. Medicaid's role as insurance for low-income Americans – particularly since the Medicaid expansion authorized under the Affordable Care Act – makes the program a crucial vehicle for expanding access. Extensive research and practice is underway to try to engage providers in offering, and patients in accessing, the full suite of PrEP medication and clinical services. However, there is little information available on how to drive engagement with and through state Medicaid programs in ways that optimally address provider and patient barriers.

To inform this project, this paper seeks to identify a "menu" of ways to leverage the Medicaid program to educate patients and providers about PrEP and support them in adherence to the medication and clinical services. A separate white paper discusses specific Medicaid financing mechanisms that could be used to improve uptake and comprehensive delivery of PrEP; these include mechanisms to incentivize provider engagement, and the papers should be considered jointly. The papers will inform an AcademyHealth and ChangeLab convening of Medicaid officials from select states, representatives of Medicaid managed care organizations (MCOs), public health officials, and other stakeholders in January of 2019 to consider which of the approaches discussed may be appropriate for their policy environments.

This paper begins with background information on patient and provider barriers to use of PrEP medication and clinical services. It then identifies specific types of educational resources and operational support tools that experts report would be most helpful in promoting engagement, and describes opportunities for dissemination of these resources by Centers for Medicare and Medicaid Services (CMS), State Medicaid agencies, and MCOs, including through partnering with professional societies.

The paper then reviews potential uses of Medicaid claims data to track current PrEP use, assess the provision of clinical services to PrEP users, and identify potential new users. It describes how this data could be combined with surveillance data and other information to help target and shape PrEP education and outreach efforts.

The next section discusses specific Medicaid benefits that may promote provider and patient engagement, including telehealth and medication therapy management by pharmacists. It also describes how some PrEP services could be offered by community-based organizations to support patients and prescribers, and discusses how Medicaid programs and MCOs could support those organizations.

The last section addresses several further considerations for patient and provider engagement through Medicaid, including leveraging cultural competency initiatives in state Medicaid programs, assisting PrEP users experiencing enrollment "churn," creating PrEP linkages for Medicaid-eligible people leaving the corrections system, and parsing privacy issues for adolescent minor PrEP users in Medicaid. It concludes with a discussion of considerations around promoting PrEP for people who inject drugs.

States differ in their HIV epidemics, resources, Medicaid programs, and the relationship between the HIV/public health community and the Medicaid agency. This paper does not present a one-size-fits all answer to promoting PrEP engagement through Medicaid. Rather, the goal is to outline in one place the potential tools that state-level stakeholders could use to better engage and support Medicaid providers and patients through the full PrEP intervention suite. Table 1, below, contains a high-level summary of issues to consider at the state level, based on the topics covered in this paper. After the convening in January 2019, condensed versions of the white papers will be developed as an additional tool to help stakeholders at the state level identify key action items.

Table 1: High-Level Issues to Consider at the State Level

Barriers to Patient and Provider Engagement
Is there state-level data on patient uptake of PrEP medication and clinical services, within Medicaid or overall? Are there quantitative or qualitative assessments of patient barriers to PrEP within the state?

How many and what kind of providers in the state are currently prescribing PrEP, overall and within the Medicaid program? Is there state-level evidence on barriers to provider engagement in PrEP?

Patient and Provider Outreach and Education
What general and state-specific resources would be useful for educating Medicaid enrollees in the state about PrEP?

What resources would be useful for educating current and potential PrEP providers?

What operational tools could help support both patients and providers in uptake of and adherence to PrEP medication and clinical services?

How does the state Medicaid agency communicate with enrollees and with providers?

How do Medicaid MCOs in the state communicate with enrollees and providers?

What opportunities exist for one-time and ongoing inclusion of resources related to PrEP through these communication channels?

Which professional societies would be useful partners for engaging in provider outreach within the state? Which organizations might be willing to work with Medicaid and public health stakeholders to strengthen access to and delivery of PrEP medication and clinical care among Medicaid beneficiaries?

Medicaid Data-Sharing to Target PrEP Resources and Education
What do Medicaid claims data, alone or combined with surveillance or other data, show about current PrEP use in the state? Could Medicaid claims data be used to monitor receipt of PrEP clinical services among current PrEP users?

Could Medicaid claims data be used to inform outreach to potential PrEP users based on indicators such as STI treatment?

Is there an existing data agreement between public health and Medicaid in the state? If not, could the Medicaid agency, or a third party, run analyses related to PrEP?

Are there opportunities for collaborating with specific Medicaid MCOs on analysis of their own claims data?

Using other Medicaid Benefits for Patient and Provider Engagement
How can the state's Medicaid telehealth payment policies be leveraged to expand access to PrEP medication and clinical services for enrollees? What are potential pros and cons of PrEP telehealth models for patients and providers?

Does the state Medicaid program include benefits that could be specifically leveraged to support current PrEP users, such as targeted case management or nonemergency medical transportation?

Does the state have a medical therapy management (MTM) benefit that could be used to pay pharmacists to support current PrEP users and providers? Does the state allow advanced pharmacy practice in a way that would allow further pharmacist engagement in PrEP?

Could community-based organizations (CBOs) provide some PrEP services to make them more accessible to PrEP users and reduce the burden on prescribing providers? If yes, could the CBOs be Medicaid providers or otherwise receive financial support from Medicaid agencies or MCOs?

Further Considerations
How does the state promote cultural competency in its Medicaid program and in partnership with MCOs? Could PrEP and related issues of sexual orientation, gender identify, and race be incorporated into these activities?

Are PrEP providers and users able to navigate shifting Medicaid status, including loss of insurance, changing to private coverage, or switching among MCOs?

Could screening for PrEP eligibility be included in any formal or informal processes for facilitating Medicaid enrollment for people leaving the criminal justice system?

What privacy concerns do the state's Medicaid policies present, particularly for adolescent PrEP users?

How can the provision of PrEP medication and clinical services be integrated into existing services in the state for people who inject drugs, and into new initiatives to address the growing opioid epidemic?

Methodology

AcademyHealth conducted initial discussions with the project Steering Committee (see Appendix 1) to identify the appropriate scope for this white paper. AcademyHealth staff then conducted preliminary interviews with a set of key informants to begin to develop key themes and topics for the convening and white papers. The author then conducted semi-structured interviews with additional experts in Medicaid, PrEP, and patient and provider engagement (see Table 2, below; preliminary interviews conducted by AcademyHealth are marked with an asterisk and all others were conducted by the author).

Interviews of multiple staff at the same organization or agency were combined. All interviews were conducted for the overall project, with insights from the experts incorporated into both white papers.

Table 2: Experts Interviewed for the Project

Divya Ahuja, MD, University of South Carolina Associate Professor of Clinical Internal Medicine

Jennifer Babcock, MPH, Vice President for Medicaid Policy and Director of Strategic Operations, Association for Community Affiliated Plans

Laura Beauchamps, MD, University of Mississippi Medical Center, Assistant Professor Infectious Disease; Medical Director, Open Arms Healthcare Center

Sean Bland, JD, Senior Associate, O'Neill Institute, Georgetown Law*

Sarah Calabrese, PhD, Assistant Professor of Psychology, George Washington University

John Carlo, MD, Member, American Medical Association (AMA) Council on Science and Public Health; CEO, Prism Health North Texas

Stephen Cha, MD, Chief Medical Officer of UnitedHealthcare Community & State

Megan Coleman, FNP, Director of Community Based Research, Whitman-Walker Health, DC

Edwin Corbin-Gutiérrez, MA, Senior Manager, Health Systems Integration, National Alliance of State and Territorial AIDS Directors*

Jeffrey S. Crowley, MPH, Distinguished Scholar and Program Director of Infectious Disease Initiatives, O'Neill Institute, Georgetown Law*

Vanessa Diaz, MD, MSCR, Medical University of South Carolina

Jason Farley, PHD, MPH, ANP-BC, AACRN, FAAN, Co-Director Clinical Core, Hopkins Center for AIDS Research; Immediate-Past President, Association of Nurses in AIDS Care (ANAC)

Douglas Fish, M.D., Medical Director, Division of Program Development & Management, New York State Department of Health*

Andrea Gelzer, MD, MS, FACP, Senior Vice President & Corporate Chief Medical Officer, Amerihealth/Caritas

DeAnn Gruber, PhD, MSW, Director of the Bureau of Infectious Diseases, Louisiana Department of Health*

Elizabeth Hacker, MPH, PrEP Coordinator, Detroit Public Health STD Clinic

Chad Hendry, Director of Sexual and Reproductive Health, Howard Brown Health

Kristin Keglovitz-Baker, PA-C, Chief Operating Officer and Certified Physician Assistant, Howard Brown Health

Amy Killilea, JD, Director, Health Systems Integration, National Alliance of State and Territorial AIDS Directors

Douglas Krakower, MD, Research Scientist, The Fenway Institute; Assistant Professor of Medicine and Population Medicine, Harvard Medical School; Harvard Medical Faculty Physician at Beth Israel Deaconess Medical Center

Leighton Ku, PhD, MPH, Professor and Director of the Center for Health Policy Research, George Washington University School of Public Health

Paul Loberti, MPH, Administrator for Medical Services, Project Director Health System Transformation, Project Director HIV Provision of Care & Special Populations Unit, Health & Human Services, State of Rhode Island*

Erin Loubier, JD, Senior Director for Health and Legal Integration and Payment Innovation, Whitman-Walker Health, DC

Juan Carlos Loubriel, Director of Community Health and Wellness, Whitman-Walker Health, DC

Kathryn Macomber, MPH, Director, Division of HIV/STD Programs, Michigan Department of Health and Human Services*

Kathy McNamara, RN, Associate Vice President, Clinical Affairs, National Association of Community Health Centers (NACHC)

David Neff, MD, Chief Medical Director, Michigan Department of Health and Human Services*

Sable Nelson, Esq, Policy Analyst, NMAC

Marty Player, MD, Medical University of South Carolina

Daniel Raymond, Deputy Director of Planning and Policy, Harm Reduction Coalition

Catherine Reid, MD, Office of Medical Affairs, Michigan Department of Health and Human Services*

Sandra Robinson, MBA, Chief, ADAP Branch, Office of AIDS, California Department of Public Health

Sara Rosenbaum, JD, Harold and Jane Hirsh Professor of Health Law and Policy and Founding Chair of the Department of Health Policy, George Washington University School of Public Health

David Rzeszutko, MD, Medical Director, Priority Health (Michigan)

Matt Salo, Executive Director, National Association of Medicaid Directors

Bellinda Schoof, MHA, CPHQ, Division Director, Health of the Public and Science, American Academy of Family Physicians (AAFP)

Lyn Stevens, MS, NP, ACRN, Medical Director, AIDS Institute, New York State Department of Health; Past President, Association of Nurses in AIDS Care (ANAC)*

Donna Sweet, MD, MACP, AAHIVS, Director, KU Wichita Internal Medicine Midtown and Ryan White Programs; Director and Principal Investigator, Kansas AIDS Education and Training Center

Elyse Tung, PharmD, BCACP, Kelley-Ross Pharmacy Group, Seattle

Gretchen Weiss, MPH, Director of HIV, STI, and Viral Hepatitis, National Association of County and City Health Officials (NACCHO)

Melody Wilkinson, DNP, APRN, FNP-BC, Member, American Association of Nurse Practitioners (AANP); Program Director of the Family Nurse Practitioner Program and Assistant Professor, Georgetown University

Doug Wirth, MSW, President and CEO, Amida Care (NY)

Mike Wofford, PharmD., Chief Medi-Cal Pharmacy Policy, CA Department of Healthcare Services

** Interviewed by AcademyHealth staff in preliminary interviews*

The author also conducted a search of peer-reviewed and "grey" literature on Medicaid and PrEP.

Finally, AcademyHealth conducted an informal survey of the participants in its Medicaid Medical Director Network (MMDN) regarding their FFS Medicaid coverage of PrEP medication and clinical care, as well as provider and patient engagement. Deidentified responses received from 16 states are included.

Background

This section provides an overview of the CDC's guidelines for PrEP medication and clinical services, including potential PrEP users and the schedule of recommended services. It then gives a brief overview of patient and provider barriers to engagement – not an exhaustive discussion of the literature, but an outline of key issues. For both patients and providers, it is important to note that knowledge and attitudes may have changed considerably even in the few years since PrEP was formally approved in the U.S. A state-specific assessment could help provide more targeted and current understanding of barriers to be addressed.

PrEP and the CDC's Guidelines

Pre-exposure prophylaxis for HIV, or PrEP, refers to the daily use of a medication by people who are HIV-negative to reduce the risk of seroconversion. Trials have demonstrated effectiveness of over 90 percent for consistent use among those at risk of sexual transmission, and over 70 percent for people who inject drugs.[10] This section outlines the components of the full suite of PrEP services, as well as the people for whom it is indicated, as context for the discussion of engaging patients and providers through Medicaid.

There is only one drug currently approved by the FDA for PrEP in the US: a fixed-dose combination of tenofovir disoproxil fumarate (TDF) 300 mg and emtricitabine (FTC) 200 mg, sold by Gilead as Truvada. FDA granted ANDA approval to Teva[11] and Amneal[12] for generic versions of Truvada in June 2017 and August 2018, respectively. However, neither has yet become available on the U.S. market.

All states must cover Truvada for PrEP in their Medicaid programs, but there is variation across and within states in whether barriers to access exist.

The CDC recommends PrEP be considered as one prevention option for the following people at substantial risk of HIV infection[13]:

Men Who Have Sex with Men (MSMs) (including those who inject drugs)

- HIV-positive sexual partner
- Recent bacterial STI (gonorrhea, chlamydia, syphilis)
- High number of sex partners
- History of inconsistent or no condom use
- Commercial sex work

Persons Who Inject Drugs

- HIV-positive injecting partner
- Sharing injection equipment

Heterosexual Women and Men (including those who inject drugs)

- HIV-positive sexual partner
- Recent bacterial STI (gonorrhea, syphilis)
- High number of sex partners
- History of inconsistent or no condom use
- Commercial sex work
- In high HIV prevalence area or network

In order to determine clinical eligibility, the guidelines recommend a documented negative HIV test result; an assessment to rule out signs or symptoms of acute HIV infection; a renal function test (estimated creatinine clearance); and assessment of current medications to rule out contraindications. While not part of the clinical eligibility criteria, documentation of Hepatitis B infection and vaccination status is recommended prior to initiating PrEP. The CDC recommends that once on PrEP, people receive a follow-up visit at least quarterly for an HIV test, medication adherence counseling, behavioral risk reduction support, side effect assessment, and STI symptom assessment. Renal function testing is recommended at 3 months and every 6 months thereafter. Overall, bacterial STI testing is recommended every 3-6 months for both sexually active men and women. The CDC recommends nucleic acid amplification (NAAT) STI testing at sites of potential sexual exposure including pharyngeal and rectal testing for MSM, as well as rectal testing for women who report engaging in anal sex. Providers should offer pregnancy tests and discussion of pregnancy intent with women every six months, and people who inject drugs should have access to clean needles and drug treatment services.

Overview of barriers to patient engagement

Many factors may hinder patient engagement along the "PrEP care continuum."[14] Key barriers identified in the literature and in interviews for this project include:

- *Lack of awareness:* Since Truvada was approved for PrEP in 2012, public awareness has increased overall.[15] However, there are still some people who could benefit from PrEP who are not aware that the option exists.[16] In the years since PrEP approval, studies have found gaps in PrEP awareness among a range of populations at high risk of HIV. For example:
  - In 2016, over 17 percent of new HIV diagnoses were among young MSM.[17] A study of young MSM across the US (median age 24) between 2013 and 2015 found that roughly a third were unaware of PrEP.[18]
  - In 2016, Black MSM were the most-affected subpopulation in the U.S., representing a quarter of all new HIV diagnoses.[19] It has been estimated that over one half of Black transgender women are living with HIV.[20] However, a study of substance-using black MSM and transgender women in New York City from 2012 through 2015 found that only 18.2 percent were aware of PrEP.[21]
  - Women accounted for 19 percent of new HIV diagnoses in 2016,[22] but less than 5 percent of PrEP users from 2014 to 2016.[23] Focus groups conducted in 2014 with at-risk women in six US cities found that nearly none had been aware of PrEP prior to the focus group.[24]

Awareness may be increasing among these and other groups, but it cannot be assumed that all potential PrEP users are aware of the option.

- *Affordability concerns:* Potential PrEP users may have heard about the costs of PrEP, particularly the medication for people without insurance.[25,26,27] Truvada has an average acquisition cost (the price pharmacies charge without insurer discounts) of approximately $1,600 per month.[28] Though cost sharing in Medicaid is nominal, these concerns may be shared by Medicaid enrollees, particularly if they are unaware that the medication and most clinical services should be covered by their program with minimal cost sharing. Fear of costs can be exacerbated when patients become aware of the additional visits and monitoring, leading to lost work hours and travel costs.
- *Concerns about side effects or drug interactions:* Patients may be concerned about side effects of taking a medication, especially for preventive purposes. However most PrEP users experience no side effects, and among the 8-10% who do (headache, upset stomach), they last only a few days. Concerns about PrEP reducing the effects of hormone therapy have been reported among transgender women.[29] To date, there are no substantive data available to corroborate these concerns. However, preliminary data do suggest that hormone therapy for transgender women can lower the efficacy of PrEP.[30]
- *Geographic barriers:* Multiple interviewers cited geography as a barrier for patients, particularly in rural settings.[31] Patients are unable to travel long distances to PrEP providers in cities, particularly for quarterly visits for monitoring and testing. Transportation can also be a barrier to regular visits for PrEP users in urban settings.[32]
- *Lack of relationship with a trusted provider who offers PrEP:* Some potential PrEP users may not have a relationship with a trusted provider who could prescribe PrEP. For example, a study of MSM in Oklahoma noted that a combination of geographic barriers and a dearth of "affirming providers" were commonly reported as barriers by MSM.[33] One interviewee who offers PrEP navigation at a public STD clinic noted that some transgender and MSM patients express not feeling comfortable discussing PrEP or sexual history with some prior providers.[34] For women, family planning clinics may be their primary or only source of trusted health care, and these providers do not always offer or discuss PrEP.[35] As discussed later in this paper, though people who inject drugs accounted for 10 percent of new HIV diagnoses in 2016, many substance use treatment providers also do not offer PrEP.
- *Perceived provider stigma:* Lack of a relationship with a trusted provider is related to perceived (and often real) provider stigma or bias. One study based on online focus groups with MSM from different parts of the country found that "[w]hen participants were asked if they would feel comfortable discussing PrEP with their own primary care physicians (PCPs), most indicated discomfort due to embarrassment or fears of being judged."[36] Stigma is multifactorial and will likely vary based on setting and other factors; for example, a study that compared focus groups of White MSM in Boston with Black MSM in Jackson found that the latter group were more likely to report provider stigma around HIV and sexual orientation.[37]
- *Internal stigma:* Potential PrEP users may also have internal biases against PrEP use. For example, in one study surveying black MSM and transgender women at a pride event in 2015 in a large southeastern city, 23 percent stated that PrEP was "for individuals who are promiscuous"; this belief was associated with lack of interest in using PrEP.[38] Similarly, a study of heterosexual, HIV-negative women who are Planned Parenthood patients in three high-prevalence Connecticut cities found:

Participants commonly perceived PrEP-user stereotypes, with many believing that others would regard them as promiscuous (37%), HIV-positive (32%), bad (14%), or gay (11%) if they used PrEP. Thirty percent would feel ashamed to disclose PrEP use. Many participants expected disapproval by family (36%), sex partners (34%), and friends (25%).[39]

The study found these perceptions to be negatively associated with comfort discussing PrEP with a provider and intention to use PrEP.[40]

Upcoming Resources on Barriers to Patient Engagement in PrEP

Four NIH-funded national cohort studies of cis, trans and gender non-conforming young men, women, and others, ages 13 and older, will begin releasing data in 2019.[181] These studies will provide further information on barriers to engagement in PrEP among these populations, helping inform national and state solutions.

Overview of barriers to provider engagement

Based on the literature and interviews conducted for this project, key barriers to provider engagement with PrEP overall include:

- *Awareness:* Since the approval of Truvada for PrEP in 2012, provider awareness has grown, but many providers are still not fully informed about PrEP. For example, one 2015 survey of academic primary care physicians found that while nearly all were aware of PrEP, two-thirds of them had not prescribed it; of these non-adopters, over 55 percent rated their knowledge of PrEP as poor or fair, and over 65 percent rated their knowledge of PrEP side effects as poor or fair.[41] In the study, self-rated knowledge of PrEP was associated with prescribing it; another study found that *actual* knowledge of PrEP (as measured with a 5-question test) was also associated with prescribing as well as intent to prescribe in the future.[42]

  Knowledge of PrEP among primary care physicians is, predictably, lower than among HIV specialists. An online survey of primary care physicians and HIV physicians found that primary care physicians were less likely to have heard of PrEP (76 percent vs. 98 percent) or to report familiarity with prescribing it (28 percent vs. 76 percent).[43] A more recent survey of primary care physicians in a university health system in North Carolina found low rates of PrEP prescribing, with "lack of knowledge" being the largest reported barrier.[44]

- *Lack of skills/experience:* Some providers may lack the skills to comfortably elicit sexual histories. For example, the study comparing primary care physicians and HIV experts found that fewer primary care physicians reported feeling "somewhat or completely comfortable" discussing sexual activities (75 percent vs. 94 percent).[45] Primary care providers may also be reluctant to begin prescribing antiretroviral medications,[46] a class with which few have experience. However, interviewees stated that overall, PrEP is a relatively simple intervention for primary care providers to manage,[47,48] and that efforts to engage more providers should not overstate the necessary skills.

- *Confusion regarding scope of guidelines:* One interviewee noted that the current CDC PrEP guidelines still leave ambiguity regarding patient criteria, and that they could potentially exclude patients who would in fact benefit from PrEP.[49] An alternative approach would be the "routinizing" of PrEP – making it a routine discussion with all adult patients.[50] In addition to preventing under-reach, this approach could help reduce the impact of bias in provider decisionmaking regarding PrEP. However, depending on implementation, this could add further burden to providers with limited time with patients.

- *Time/capacity:* Multiple interviewees noted that even when providers have the skills and willingness to counsel patients about PrEP, they may lack the time in a primary care visit with multiple other health issues to address.[51] One interviewee reported that the CDC-recommended guidelines for ongoing STI testing may be daunting for primary care providers.

- *Concerns about unintended consequences:* Across multiple studies, providers report concerns about the unintended consequences of PrEP, including the development of resistance; potential lack of adherence; and the possibility of risk compensation, i.e. PrEP users increasing risky behaviors.[52,53,54,55]

- *Questions about cost and reimbursement:* Some providers are unaware of how to seek reimbursement for PrEP, or how to assist patients in accessing PrEP without burdensome cost sharing.[56]

- *Lack of clear sense of responsibility for PrEP:* Many HIV specialists believe that scale-up of PrEP needs to occur in the primary care setting where most persons without HIV infection get care, yet many primary care providers believe they lack the time and expertise to offer PrEP, a dilemma described by Krakower et al. as the "purview paradox."[57] Meanwhile, while STD clinics may be seen as a logical place to reach people at high risk of HIV, a lack of funding and capacity may be challenges. One interviewee noted that STD clinics may aim to start patients on PrEP and transition them to a primary care provider[58], but that referrals could lead to lower persistence in PrEP use.[59]

  Overall, there was consensus among interviewees that more providers need to offer PrEP services, and most interviewees for this project concurred that uptake among primary care providers is crucial.[60] However, one interviewee opined that in a practice with only a handful of PrEP-eligible patients, it may make more sense to refer them to providers with substantial numbers of PrEP patients than to manage them directly.[61]

- *Stigma and Bias:* Provider resistance to engaging in PrEP can be rooted in conscious or subconscious bias based on race, sexual orientation, gender identity, sexual behavior, socioeconomic factors, or a combination. For example, one study that presented medical students with a vignette involving an MSM patient seeking PrEP found that participants reflecting higher levels of heterosexism were more likely to anticipate adherence problems and risk compensation, leading to lower intention to prescribe.[62] Another study of medical students found greater belief that a hypothetical black patient would engage in risk compensation compared to a white patient, a factor that again was associated with reported lower likelihood to prescribe.[63] Studies of MSM in varied geographic settings have found perceived provider stigma to be a barrier to asking about PrEP or discussing relevant sexual behaviors.[64,65]

  Bias may be an issue among other staff in medical settings. Implicit (or explicit) bias among receptionists, nurses and other staff can affect patients' willingness to utilize or even ask about PrEP.

Providers and PrEP: the Information-Motivation-Behavioral Skills Model

The Information-Motivation-Behavioral Skills, or IMB, model, could be one framework for considering provider engagement in PrEP.[182] Information would involve making providers aware of PrEP and addressing misconceptions. Motivation could be extrinsic (e.g. CME requirements, set protocols) and intrinsic (getting provider buy-in, based on PrEP's unique benefits, such as being user-controlled, private, effective for both PWID and sexual risk, and effective for discordant couples, including those who wish to conceive). Finally, behavioral skills can be developed through concrete guidelines and resources, including checklists, scripted language, hands-on training and education materials (see below for further discussion of specific materials and resources).

Leveraging the Medicaid program to engage patients and providers

This section provides an overview of resources to educate patients and providers about PrEP and of operational tools to support adherence to the medication and clinical services. It then describes how these resources could be disseminated in the Medicaid program by three potential "messengers": CMS, state Medicaid agencies, and Medicaid MCOs. State Medicaid agencies or MCOs can work with public health stakeholders to identify the appropriate set of resources, messages and communication channels for distribution within a given state or region.

Patient and provider educational resources and operational tools

This section describes the scope of resources that could be used to educate and inform patients and provider about PrEP, and the operational tools that could help support continued engagement in PrEP among provider and adherence among PrEP users.

Patient and provider educational resources

There are a wide range of resources that could be shared with patients and providers to educate them about PrEP. In collaboration with Medicaid agencies and MCOs, public health agencies may play a role in the development of any new or specifically tailored materials. Existing examples of many of these resources are available, for example through Project Inform at www.projectinform.org/prep/.

For patients, information could include:

- Culturally competent and accessible information about PrEP services.
- State-specific information on how Medicaid covers PrEP medication and clinical services.
- PrEP locator information (i.e. a url for a site for finding PrEP providers). The existing website https://preplocator.org is a searchable directory of clinics and providers who offer PrEP. It is not exhaustive – relying on direct submissions or confirmations from providers – but may be a good starting point. Some health departments have developed their own PrEP provider directories, using the central preplocator tool or their own maps.[66] Optimally, a directory would include information on how to find a PrEP provider participating in the Medicaid program (as included in the directory provided by the North Carolina AIDS Education and Training Center)[67] or in specific Medicaid MCO networks.

For providers, based on the literature review and interviewees, the following educational resources could be considered for dissemination through the avenues described in this section.

- **The CDC's PrEP guidelines and provider education tools**. Multiple interviewees noted that providers would consider the CDC's existing guidelines to be a trusted source of information. While some providers – or patients – may find their way to the guidelines online or through other sources, they and any future updates should remain a key component of provider outreach, along with the CDC's PrEP education resources and tools for providers.[68]
- **State-specific information**. Multiple interviewees noted that providers would benefit from state-specific information. This could include:
  - Any relevant recommendations or guidelines from the state DOH. For example, DC has developed a provider guide with District-specific PrEP and PEP information and guidelines.[69]

  - Information about the state's Medicaid program and parameters for coverage of PrEP medication and clinical services, including billing and coding information.

- **Education on taking sexual histories.** One interviewee noted that sexual histories should be part of routine medical care, beyond just a screening tool for PrEP[70]; similarly, another noted that discussing sexual history can be useful for some patients even if they are not ready for PrEP.[71] Resources for providers could include materials on taking sexual histories, such as SIECUS's guide to taking sexual histories for providers serving LGBT youth.[72]
- **Continuing education on PrEP**. Providers should be made aware of continuing education (CE) resources on HIV prevention, including PrEP. In general, CE is available for physicians as well as nurse practitioners, physician assistants, and registered nurses. CE on PrEP could increase knowledge while allowing providers to meet their state-level requirements.
- **Availability of PrEP academic detailing**. A number of states and cities have developed "academic detailing" programs on PrEP, offering training to providers to increase adoption of PrEP prescribing as well as of CDC-recommended clinical services.[73,74,75] Providers could be informed of the availability of any such opportunities in their state or region.
- **PrEP Locator Resources**. As an interviewee noted, the Preplocator.org directory or state-specific directories may be useful not only for patients but also for providers, allowing prescribers who are new to PrEP to contact other providers in the area with initial questions or for ongoing peer support.[76]

The U.S. Preventive Services Task Force

A positive recommendation from USPSTF could represent an important opportunity for engaging patients and providers, both through and outside the Medicaid program.

First, within Medicaid, the elimination of some cost-sharing for expansion enrollees could be an important shift. While Medicaid cost sharing is generally "nominal" and in most states must be waived by providers and pharmacies if requested, even small out-of-pocket costs can be a deterrent to care. In addition, the perceived cost of PrEP may be a barrier to patient access, even though costs for Medicaid enrollees would be relatively modest. To the extent PrEP can be advertised as entirely free for Medicaid patients, concerns about cost could be reduced as a barrier for Medicaid enrollees.

Second, many interviewees agreed that a positive USPSTF recommendation for PrEP could encourage more providers, particularly primary care providers, to offer the service. Therefore, a positive recommendation could help address the "purview problem" by specifically validating PrEP as an intervention that belongs (though not exclusively) in the primary care setting.

Operational support tools for patients and providers

In addition to educational materials about PrEP, both providers and patients could benefit from a range of operational "tools" and resources to support ongoing provision of, and adherence to, PrEP medication and clinical services. While some of these supports would be specifically provider-facing – such as workflow models for PrEP delivery – others, such as text platforms, could support both patients and providers by facilitating reminders and communication.

- **Workflow sheets or algorithms**. Providers, particularly those new to PrEP, could benefit from a workflow model or algorithm that walks through the steps of PrEP offer, initiation, and ongoing monitoring.[77,78,79] For example, the New York State Department of Health developed quick reference cards for PrEP that could be attached to provider lanyards for clinical use.[80] One interviewee described educational materials she developed for Planned Parenthood's PrEP provider training program, which included scripted language for patient encounters.[81]
- **Standardized prior authorization form.** It may be appropriate to develop clear, standard prior authorization (PA) forms for PrEP medication to simplify requests on the provider side. While PA can in theory pose a barrier to access to PrEP, a simple form linked to relevant clinical information (e.g. demonstrated HIV-negative status at initiation) may be less of a barrier.
- **Consumer communication tools.** One interviewee, a PrEP navigator, reported that her calls to current PrEP users – to remind them of followup visits or to check on patients who miss visits – help promote compliance with ongoing monitoring.[82] She noted that a texting program for PrEP users could also be helpful, possibly for medication reminders or allowing questions by text. As noted in the textbox below, the VA's toolkit for PrEP engagement includes PrEP-specific messages in the system's text messaging system. A text message platform for youth PrEP users was recently found to increase PrEP adherence among youth at high risk of HIV acquisition[83]; the tool will be integrated into larger demonstration projects.[84]
- **Patient screening tools**. Interviewees noted that both patients and providers would benefit from simple patient screening tools. Multiple interviewees recommended disseminating questionnaires that patients could complete on their own, either before a visit or while waiting in the waiting room or exam room.[85,86] These tools could make some patients more comfortable answering questions related to sexual history. In addition, they would save provider time, and address the barrier of discomfort taking sexual histories for some providers. Such tools are already available; for example, the CDC has developed a six-question MSM risk index for PrEP and a seven-question risk index for people who inject drugs.[87] The Stigma Project has developed the CDC guidelines into a user-friendly screening tool.[88]

- **Patient counseling supports.** Providers and patients could benefit from tools to help PrEP users remain engaged. For example, the Integrated Next Step Counseling model, developed for the iPrEx study, guides providers through a patient-centered discussion of PrEP, with an emphasis on PrEP adherence.[89]
- **National Clinical Consultation Center**. The National Clinician Consultation Center at UCSF, funded by the CDC as part of the Health Resources and Services Administartion's (HRSA) AIDS Education and Training Center (AETC) program, has a provider warmline (PrEPline) offering free phone consultations to provide clinical advice on PrEP.[90] Medicaid programs and MCOs could also disseminate information on training opportunities from other AIDS Education and Training Centers.[91]
- **Other expert consults.** One interviewee noted that it would be helpful to have some kind of reimbursement for PrEP "peer support" for primary care providers.[92] Another interviewee who is an infectious disease doctor serves as a peer consult on PrEP within the clinical network that employs him, offering support usually via email. These consults are not reimbursed by Medicaid or other payers.[93] Similarly, a different interviewee conducts a Project ECHO-type consultation model for PrEP for primary care providers within his state; participants get CME credit, but no reimbursement.[94]

Conduits for engaging patients and providers through the Medicaid program

This section discusses how PrEP education resources and operational support tools could be disseminated by CMS, state Medicaid agencies, and MCOs. It also describes potential partnerships with professional societies to amplify provider engagement efforts.

CMS level

CMS administers the Medicaid program at the federal level. Generally, the agency is fairly removed from direct interaction with Medicaid patients and providers, communicating instead with state Medicaid agencies through Dear State Medicaid Director Letters, Informational Bulletins, and other guidance documents.[95] However, CMS did mention provider PrEP education in a 2016 joint informational bulletin with HHS, HRSA, and the CDC:

> Additional strategies states may consider to ensure that utilization management techniques are not designed or implemented in ways that amount to denial of access to PrEP among persons for whom it is indicated include 1) provider education, 2) development of clear policies and procedures for assessing and making determinations about indications for PrEP, and 3) careful review and monitoring of Medicaid FFS and managed care benefits and coverage.[96]

Veterans Health Administration: PrEP Materials and Resources for Patients and Providers

The VA convened a National PrEP Working Group in 2017 to develop targets for PrEP uptake.[183] To begin to meet these goals, the VA developed a set of products to increase uptake and awareness across the system; these included a PrEP awareness communication tool, PrEP training modules for providers, a VA blog on PrEP, and AIDSVu reports showing regional HIV risk. Further materials included academic detailing training modules and virtual PrEP training for clinical pharmacists. To facilitate targeting of PrEP to high-risk groups, the VA developed clinical support tools to identify candidates for PrEP, telehealth protocols for PrEP, and social media awareness campaigns.

- The VA also developed a set of clinical support tools to specifically address the quality of ongoing clinical care for PrEP users, including lab monitoring. These tools include:
- a set of clinical considerations, aligned with the CDC's guidelines;
- a "PrEP clinical criterion check list";
- other clinical support tools, including prepopulated EHR templates and order menus for PrEP initiation and monitoring; and
- PrEP-related texts in the VA's text-messaging system, to support adherence, appointment attendance, tracking, and patient education.[184]

Building on items 1 and 2, the CDC could ask CMS to consider disseminating materials to inform specific provider education at the state level, as well as tools for developing clear procedures for providers to help them make determinations about which patients are candidates for PrEP. These provider capacity assessment and support tools could be modeled on the approach CMS has taken with regard to substance use disorder, offering clinical resources guides, a national workshop, and a range of webinars, both live and archived.[97]

The CDC could also collaborate with HRSA's Bureau of Primary Health Care (BPHC) to address patient and provider issues at FQHCs.

State Medicaid agencies

State Medicaid agencies could disseminate PrEP resources through a range of communication channels, identified through interviews for this project as well as AcademyHealth's informal survey of its Medicaid Medical Director Network (MMDN).[98] For patients, states could include brief information about PrEP in initial enrollment materials and ongoing mailings to enrollees. Some respondents to the MMDN survey also reported using enrollee emails and automated calls.[99] An important caveat noted by two MMDN

respondents is that in states with high managed care enrollment, states might not communicate directly with enrollees.

State Medicaid agencies could use their agency websites to highlight key PrEP resources both for patients and providers, including specific information on coverage for both, as well as on billing and coding details for providers. Some states may have specific sites for information related to pharmacy; for example, California Medi-Cal's Drug Use Review program has an educational intervention component regarding drug-specific therapy issues.[100]

State Medicaid agencies can also reach providers through a range of approaches:

- *Provider manuals.* Provider manuals can lay out service standards for provision of PrEP medication and clinical services, as well as links to resources for further education and support.
- *Emails and/or newsletters to providers.* Most state Medicaid agencies have regular communiques to providers noting updates such as formulary or billing changes, or highlighting certain key policies. For example, New York State's Medicaid program sends a monthly update to providers, largely focused on billing and policy issues.[101] These communications may be electronic; five of the sixteen respondents to AcademyHealth's survey specifically noted email as an effective way to reach providers.[102]
- Some newsletters may be read more often by administrative staff than by providers themselves and therefore may be appropriate outlets for highlighting and providing links to key PrEP billing and coding resources.
- *Direct letters to providers* regarding PrEP. The State Medicaid agency could send letters to all Medicaid providers in the state, or to targeted subsets, specifically highlighting PrEP resources.
- State Medicaid agencies could also use "all-plan letters" to encourage MCOs to share PrEP information with participating providers and with enrollees.

Examples of State Medicaid Outreach to Medicaid Providers

In December 2017, California's Department of Health Care Services sent a notice to all Medi-Cal providers regarding erroneous delays and denials of PrEP and PEP, and clarifying that both are covered services available through Medi-Cal.[185]

In New York, the Department of Health (DOH) learned of provider confusion over Medicaid coverage of PrEP and PEP in Fee for Service Medicaid. DOH developed a document for distribution to all Medicaid FFS providers to clarify coverage policies.[186]

Lessons from MCO Provider Engagement Efforts Related to Medication-Assisted Treatment for Opioid Addiction

A recent report for the Association for Community-Affiliated Plans detailed the strategies that several Medicaid MCOs are using to support and engage primary care physicians in prescribing Medication-Assisted Treatment (MAT) for opioid use disorder.

The authors of the report identified provider barriers to offering MAT that in several ways echo those involved with PrEP: a lack of provider education, the additional management burden of MAT practice, and stigma related to the patient population and to the underlying risk behavior.

Medicaid MCOs profiled in the report used a variety of approaches to engage new MAT providers and to support and maintain existing providers. For example:

- UPMC (Pa.) supports educational sessions in medical schools, as well as training opportunities for providers, including webinars, conferences, and on-site presentations.
- UPMC supports physicians who are on call at all hours to answer questions from prescribing physicians, as well as a 24-hour care management services for patients and providers.
- Community Health Network of CT offers a two-day conference on addiction, opioid use disorder and MAT, with 16 free CME credits, for its providers. It also offers online toolkits for primary care providers and emergency room-based providers.
- Inland Empire Health Plan (CA) has a payment structure that support out-of-office time for trainings related to MAT.
- Multiple MCOs support Project ECHO models related to opioid use. For example, Passport Health Plan (Ky.) is engaged in a Project ECHO collaborative to support buprenorphine prescribing, particularly for rural providers; and Partnership Health Plan (Calif.) uses the ECHO model to train primary care providers on treating chronic pain. Partnership Health Plan has also engaged a MAT provider who visits network practices to support MAT implementation.
- Three health plans – Inland, Passport, and UPMC – are developing consistent screening processes to identify patients with opioid use disorder. Geisinger Health Plan uses ICD codes to identify candidates for targeted outreach.
- Geisinger Health Plan conducted an internal survey of its physicians regarding addiction in SUD, in part to identify and address provider bias and stigma.

It is important to note that state Medicaid agencies may be concerned that patient or provider outreach will drive a demand for PrEP that the state cannot afford to meet.

Medicaid MCOs

MCOs can provide information directly to their own enrollees. Enrollee MCO manuals could include basic information on PrEP and how to learn more, as well as information on finding a PrEP provider specifically within that MCO's network. MCOs could

also send information about PrEP to all members or to specific zip codes, targeted based on Medicaid claims data analysis and/or state surveillance data.[103]

Medicaid MCO websites usually have both enrollee and provider interfaces. The enrollee website could link to basic consumer information about PrEP and how to access it; the provider interface, targeted to in-network providers, could highlight provider resources on PrEP.

MCOs can reach out to providers through additional channels:

- *Provider manuals*: Provider manuals can lay out service standards for provision of PrEP medication and clinical services, as well as links to resources for further education and support.
- *Provider mailings:* Like state Medicaid agencies, MCOs routinely send regular or special communications to providers on key coverage or policy issues, which could highlight PrEP resources. This outreach could be targeted based on Medicaid claims data analysis and/or state surveillance data.[104]
- *CME:* Medicaid MCOs can highlight, sponsor, or otherwise promote CME for their providers. MCOs could work with public health agencies to incorporate PrEP-related provider education into these opportunities.
- *Medical Affairs:* MCOs' Medical Affairs offices can reach out directly to providers for informational engagement on a range of clinical topics,[105] and could consider including PrEP in the scope of this outreach.

Finances are a crucial consideration for MCOs. MCOs may be hesitant to engage in patient and provider outreach if they are concerned that the rates they receive from the state would not adequately reimburse any ensuing uptake in PrEP medication and clinical services.

Partnering with provider organizations

Multiple interviewees cited the CDC as a primary source of trusted information for providers, including primary care providers, reinforcing the idea that Medicaid programs could add value simply by highlighting the CDC's PrEP guidelines and resources. However, interviewees also noted a range of other professional societies to which providers turn for information. Of 16 state Medicaid Medical Directors responding to AcademyHealth's informal survey for this project, five specifically noted the important role of medical professional societies in helping reach providers.[106] Medicaid agencies, MCOs, and public health agencies could reach out to these professional organizations at the national, state, and/or local levels to identify opportunities for promoting PrEP engagement and education among providers.[107]

Provider organizations could also work closely with Medicaid agencies and MCOs to help assess and strengthen policies related to coverage of PrEP medication and clinical services. Alternative financing opportunities may be more likely to come to fruition if providers, as well as public health stakeholders, are engaged in the process.

Multiple interviewees noted that providers often trust information developed at the state level as particularly responsive to their and their patients' needs. This would include state-level chapters of the organizations discussed below, as well as information from respective State Departments of Health.

Several organizations already have longstanding relationships with the CDC's Division of HIV/AIDS and could be strong partners in continued work to promote PrEP access within Medicaid. The National Medical Association represents more than 50,000 African American physicians and their patients, and promotes professional education and scholarship as well as responsive health policy and consumer education.[108] The National Hispanic Medical Association represents 50,000 Hispanic physicians in the U.S. and also engages in provider and patient engagement as well as policy work.[109] The American College of Physicians serves a similar role with regard to internal medicine specialists and subspecialists.[110]

Other professional societies could represent further opportunities for reaching and supporting new PrEP providers and patients. Affiliates of three, the AMA, AAFP, and AANP, were interviewed for this project:

- **American Medical Association (AMA)**: The AMA is a professional organization for all physicians, both MDs and DOs, as well as medical students. In 2016, the AMA adopted a policy supporting improved provider education on PrEP for HIV, noting that a 2015 survey had found that 34 percent of primary care physicians and nurses had never heard of the intervention.[111] The AMA simultaneously endorsed policies in support of full insurance coverage of the costs associated with PrEP as well as the development of policies to provide PrEP for free to high-risk individuals.[112]

  Nationally, the AMA has several member groups, or "Sections," that may be particularly interested in PrEP; these include the Advisory Committee on LGBTQ Issues and the Minority Affairs Section.[113] The AMA also maintains a "Federation of Medicine" directory of state-level medical associations, including specialty associations. The directory includes society names, leadership, contact information, and websites.[114] Stakeholders could use this resource to identify state-level physician societies and discuss ways to work together to promote AMA's policy on PrEP education.

- **The American Academy of Family Physicians (AAFP)**: The AAFP is a membership organization for family physicians who serve patients of all ages in a wide variety of settings, including offices, hospitals, community health centers, urgent care centers, and emergency rooms.[115] It currently has 131,400 members, including medical students and residents.[116] The AAFP develops practice guidelines for family physicians. These are often based on US Preventive Services Task Force recommendations: the AAFP reviews all USPSTF clinical preventive services recommendations and develops its final recommendations based on the evidence base from the USPSTF. AAFP's current policy on "Prevention and Control of Sexually Transmitted and Blood Borne Infections" states that "[f]amily physicians should counsel and when appropriate prescribe PrEP as a routine part of STI prevention."[117]

  The AAFP has 55 constituent chapters that are involved in education, messaging and promotion for family physicians within the state. They often follow national priorities, but can engage on specific issues independently, and may be open to approach for collaboration on PrEP issues.[118] Stakeholders should consider reaching out to their states' AAFP chapters regarding state-specific opportunities for increasing PrEP access in the state's Medicaid program and overall.

- **The American Academy of Nurse Practitioners (AANP)**: The AANP is a national provider organization for Nurse Practitioners across all specialties, as well as nursing students. AANP is viewed as a key source of education and information driving NP practice, including by hosting CME and other educational materials on its website.[119]

- The AANP also maintains an online directory of state, local, and regional organizational members.[120] Stakeholders could reach out to relevant organizations in the state to discuss potential collaboration on PrEP education and promoting PrEP through Medicaid.

Other professional societies to consider including in PrEP planning and engagement efforts include, but are not limited to, state primary care associations and state chapters of the American Academy of Physician Assistants and the American Academy of Pediatrics. In addition to professional societies, stakeholders should consider partnering with organizations that represent specific types of facilities. For example, NACCHO, the National Association of County and City Health Officials, has an educational series on PrEP for local health departments.[121]

Using Medicaid data to target PrEP resources and education

Multiple interviewees agreed that Medicaid claims and encounter data could be leveraged to increase PrEP uptake and adherence and to improve provision of PrEP clinical services to current PrEP users. Because Medicaid agencies do not always have staffing or resources to spare for new analyses,[122] public health stakeholders could develop or expand existing data sharing agreements with state Medicaid agencies, or work together to identify a third party, such as a university,[123] that could conduct the analyses.[124]

In an important caveat, two interviewees noted that "real-time" use of Medicaid claims data is generally not feasible,[125] due in part to lags in claims processing.[126] Despite this limitation, Medicaid claims data could potentially be used in at least three ways:

- Identifying the current rate of PrEP use in the Medicaid program, including stratification by certain populations;
- Tracking the provision of clinical services to current PrEP users;
- Identifying candidates for PrEP, based on STI-related claims or other indicators from Medicaid data.

These analyses and any related outreach to providers or patients would need to be conducted in line with existing privacy agreements as well as community expectations.

Measuring current PrEP use in the Medicaid program

First, Medicaid claims data can be used to identify who is receiving PrEP. New York State's AIDS Institute applied an algorithm to state Medicaid pharmacy and diagnosis data to identify enrollees who were on Truvada for more than 30 days,[127] excluding those with an HIV diagnosis.[128] In California, a recent analysis of PrEP uptake among Medi-Cal beneficiaries looked at changes in utilization from 2013 to 2016, stratifying data by age, gender, race, ethnicity and region to assess patterns and disparities that could help guide public health efforts to promote uptake.[129]

Similar analyses in other states could help establish a baseline for PrEP use among Medicaid enrollees and allow tracking of the impact of Medicaid-specific or statewide promotion efforts. The CDC's recent paper estimating the number of adults with PrEP indications includes figures by state and includes stratification by transmission risk group and race/ethnicity,[130] making it a useful tool for comparing PrEP access in the Medicaid program to estimated need. Identifying active PrEP prescribers in Medicaid can help states determine if communities with high PrEP need – e.g. with high STI rates – have sufficient access. Stakeholders may also wish to explore potential integration of Medicaid claims data with AIDSVu data on PrEP use.[131]

An important limitation is that data on race is often missing from Medicaid claims. In addition, claims data do not capture gender identify or sexual orientation, limiting the ability to answer certain key access questions.[132] This is one effect of an overall lag in SOGI (sexual orientation and gender identity) data collection in Medicaid programs, posing a challenge for assessment of baseline need and progress in reaching people with PrEP and other services.[133]

A further limitation is the lookback period could result in somewhat outdated utilization counts. Nonetheless, such an analysis would offer some important baseline information about how well a state Medicaid program is reaching enrollees with PrEP.

Tracking provision of clinical services to current PrEP users

Medicaid claims data could also be used to track whether people currently using PrEP are also receiving appropriate clinical services. For enrollees identified as PrEP users based on the type of analysis described above, a *lack* of claims for STI screening or other components of PrEP services could indicate that appropriate clinical services are not being provided.[134]

Claims-based analyses would only identify services reimbursed by Medicaid, omitting, for example, screenings obtained at a non-billing STI clinic.[135] However, this approach could at least flag patterns (by region or provider) of potential non-receipt of appropriate services. Such an analysis could potentially be utilized to inform targeted provider outreach, either by Medicaid agencies or public health counterparts.

Finding candidates for PrEP

Medicaid claims data could also be used to identify enrollees who are candidates for PrEP. For example, certain STI diagnoses within Medicaid claims might indicate patients whose providers could be encouraged to offer information about PrEP. Such information could also potentially be found in state surveillance data[136]; for example, Michigan's "Data to PrEP" program uses surveillance data to identify and conduct PrEP outreach to HIV-negative men with a single rectal gonorrhea infection, two urethral or pharyngeal gonorrhea infections, or syphilis. Incorporating Medicaid claims data into such initiatives might help fill gaps left by incomplete reporting to departments of health.

Medicaid Claims Data and MCOs

Generally, State Medicaid agencies have access to all claims data for their enrollees, whether FFS or managed care. However, MCOs receive their own payment data first, and may have relatively sophisticated analysis capacity.[187] In some states, it may make sense for MCOs to conduct PrEP-related data analysis for their own covered populations. In all states with MCO enrollment, Medicaid agencies, MCO, and public health stakeholders can work together to ensure reporting of those elements of encounter data that are important for PrEP analysis.

Leveraging Medicaid benefits for patient and provider engagement

This section describes specific Medicaid benefits that could be leveraged to better engage patients and/or providers in the full PrEP intervention suite. The section reviews PrEP and telehealth in Medicaid; as well as additional Medicaid benefits, like nonemergency medical transportation, that could assist PrEP users. It also discusses how Medicaid can support both pharmacists and non-clinical CBOs in bolstering patient and provider engagement.

PrEP and telehealth in Medicaid

Telehealth options for accessing PrEP could increase patient access, mitigating both geographic and other barriers to care.

As of spring 2018, 49 states and DC provide for Medicaid reimbursement of some form of live video telehealth services.[137] Roughly half of states specify a specific set of facilities that can serve as "originating sites" where the patient may be; only ten states permit a patient's home to be the originating site.[138] Telehealth coverage in Medicaid can vary by service type. Among MCOs, for example, a 2017 survey found that 37 percent of Medicaid MCOs use telemedicine for mental health or SUD counseling, along with 20 percent for chronic disease management; 32 percent did not use telemedicine.[139] In addition, some multistate Medicaid MCOs provide their enrollees with free access to national telehealth service providers, such as Teladoc.[140]

Several telehealth models for PrEP exist. For example, in New York State, the AIDS Institute identified rural counties with limited PrEP access.[141] They then worked with an FQHC in the region that had engaged in HIV treatment telehealth to establish a system for PrEP telehealth. The FQHC reached out to clinics in the underserved communities to begin providing PrEP to patients at those clinics, with the local providers present in the room so they could become comfortable with PrEP provision themselves.

Louisiana recently launched a Tele-PrEP program. Via a HIPAA compliant video platform, patients can use a computer, tablet, or smartphone to interact with a nurse practitioner located in New Orleans; a tele-PrEP navigator connects the patients to lab services.[142] For patients with Medicaid, Medicaid will pay for the drugs.

In one current trial of telehealth vs. standard PrEP, patients see a provider on camera, and HIV and STI kits are sent to the home for self-swabbing and finger sticks.[143] Subjects' insurance pays for the telehealth encounters, but study funds are being used to purchase the home test kits. If such a model is identified as an effective approach more broadly, it may be important to identify an avenue for Medicaid or alternative reimbursement of at-home test kits.

Additional Medicaid benefits to support PrEP Users

A number of additional Medicaid benefits could be leveraged to promote patient access to PrEP by addressing barriers to access and adherence:

- Targeted Case Management: Medicaid programs can support Targeted Case Management for specific groups of enrollees. Rhode Island has expanded this concept to make TCM available for certain beneficiaries at high risk of HIV,[144] creating a reimbursement mechanism for services around linking people to PrEP and encouraging their adherence to PrEP clinical services.
- Care Coordination: Many Medicaid MCOs conduct a range of care coordination activities for enrollees, including chronic disease management; community health workers, peer support specialists, and health coaches; individualized care plans; and home visits. These approaches could be tailored toward supporting PrEP users in adherence and receiving clinical services, potentially via PrEP navigators.[145] For example, MCOs could work with public health agencies to develop models for supporting PrEP navigation counselors at the plan or provider level.
- Non-Emergency Medical Transportation (NEMT) Benefit: Non-emergency medical transportation is a Medicaid benefit that covers transportation to non-emergency, Medicaid-covered care. By federal regulation, state Medicaid plans must "[s]pecify that the Medicaid agency will ensure necessary transportation for beneficiaries to and from providers; and [d]escribe the methods that the agency will use to meet this requirement."[146] States have considerable latitude in how they implement this requirement, and several states have implemented waivers of the requirement for certain categories of beneficiaries. Stakeholders could review their respective states' NEMT benefits to determine what, if any, transportation resources are available to PrEP-eligible enrollees and include information about the availability of free transportation in PrEP outreach materials.

In addition to these specific benefits, funding models such as PCMHs, Medicaid health homes and ACOs could provide care coordination services to help support PrEP users in adhering to the full PrEP intervention.

Engaging pharmacists to support patients and providers

Increasing pharmacist engagement in various elements of PrEP delivery could help improve patient access and engagement. A recent synthesis of evidence on models for PrEP delivery noted several benefits of pharmacy engagement in PrEP, including the possibility of evening and weekend hours (not always available at providers' office), and pharmacists' ability to review and respond to refill gaps to address nonadherence.[147]

In some states, Medicaid reimburses pharmacists for enhanced medication therapy management, or MTM, services.[148] For example, Mississippi Medicaid's "Pharmacy Disease Management" program reimburses pharmacists for counseling enrollees with a range of diseases including diabetes, asthma, and hyperlipidemia.[149] States with a Medication Therapy Management benefit in their Medicaid programs could explore the possibility of reimbursing pharmacists for providing enhanced counseling and reminders for patients using PrEP.[150]

In addition to engaging patients, an MTM benefit could reimburse for pharmacist engagement with prescribers. For example, a pharmacist who notes that a patient didn't pick up her PrEP prescription could reach out to the prescriber to flag the issue.[151] Conversely, a pharmacist who notices that a patient has multiple refills on their PrEP medication could reach out to the prescriber to ensure that there is a mechanism for the patient to receive required STI, HIV, and other screenings as needed each quarter.[152]

Some pharmacists may be able to conduct HIV testing[153] and possibly collect specimens and forward to a laboratory for other PrEP-related tests (e.g. STI tests with patients self-swabbing). In states that allow advanced pharmacist practice or collaborative practice agreements with clinical practices, pharmacists may be able to actually prescribe PrEP *and* offer clinical services, offering patients the full range of PrEP services at one site. For example, pharmacists at Kelley-Ross Pharmacy in Seattle can prescribe PrEP and offer the full range of CDC-recommended clinical services, receiving Medicaid reimbursement from the Medicaid MCOs with which they contract.[154]

Linking providers to CBOs to support comprehensive care for patients

Providers can partner with community-based organizations to reduce barriers for patients and facilitate provider provision of PrEP, either by offering PrEP navigation or other services like medication adherence support.

For example, clinicians at Open Arms Health Care Center in Jackson, Miss., provide PrEP. Open Arms is affiliated with My Brother's Keeper, a CBO with satellite sites in Hattiesburg and near the Coast. Patient can go to My Brother's Keeper for rapid HIV tests and bloodwork, combined with a telehealth visit with a provider at Open Arms. This reduces transportation time and costs for patients.[155]

At the Medical University of South Carolina (MUSC), the Department of Family Medicine partners with Palmetto Community Care (formerly Low Country AIDS Services) in the provision of PrEP.[156] Palmetto Community Care refers patients to MUSC, where providers can conduct initial assessments and prescribe PrEP. Patients can

then return to PCC for regular labwork, the results of which are shared with the prescribing provider at MUSC. This relationship makes labwork and PrEP adherence support more accessible for patients, while relieving the primary care clinic of some of the work of ongoing monitoring.[157]

Stakeholders should determine whether these relationships exist or could be fostered. To the extent possible, if CBOs are staffed in a way that makes them eligible Medicaid providers, they could be reimbursed for services offered. Non-clinical CBOs could attempt to develop contractual relationships (or MOUs) with state Medicaid agencies or MCOs to help support the provision of services.

NMAC's HIV and PrEP Navigation Program

NMAC's "Linking Communities to Care through HIV and PrEP Navigation" provides capacity building for non-clinical CBOs and health care organizations to offer PrEP and HIV care navigation services.[188] The program focuses on recruitment, linkage, and retention for people of color, focusing on communities most affected by HIV risk. Online resources include a landscape assessment on HIV and PrEP Navigation as well as a guide on motivational interviewing for HIV and PrEP.

Further considerations

This section addresses additional considerations for engaging patients and providers in PrEP medication and care through the Medicaid program:

- State and MCO cultural competency requirements as a potential nexus for efforts to address various forms of stigma surrounding PrEP;
- The importance of recognizing Medicaid "churn" and guiding consumers through eligibility changes while continuing to adhere to the PrEP intervention suite;
- Mechanisms for coordinating PrEP for people returning to the community from the corrections system; and
- Adolescent minors and privacy within Medicaid.

It closes with a discussion of addressing PrEP for people who use drugs, particularly in light of heightened attention to the opioid epidemic.

Cultural competency in Medicaid programs

Federal regulations require state Medicaid programs to develop methods to promote culturally competent services:

> **Access and Cultural Considerations.** The State must have methods to promote access and delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These methods must ensure that beneficiaries have access to covered services that are delivered in a manner that meets their unique needs.[158]

Further, regulations require all Medicaid MCOs – as well as limited benefit Medicaid managed care plans called Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs) – to participate in these state activities:

> Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.[159]

States could identify existing Medicaid and MCO activities to promote cultural competency, and explore opportunities to incorporate information related to PrEP, as well as to broader education to address stigma and bias related to race, sexual orientation, and gender identity.

Assisting patients with PrEP adherence through enrollment changes

An individual's Medicaid status is not static. For example, people may lose eligibility for Medicaid because of increases in income, becoming eligible instead for subsidized coverage through state-level marketplaces under the Affordable Care Act. In non-Medicaid expansion states, people who are eligible for Medicaid under very low income thresholds could lose eligibility at a slightly higher income level and become uninsured. In all states, people may lose eligibility for administrative reasons such as failing to complete paperwork in a timely fashion.

Churning can have serious impacts on access to care. A recent study of 2015 data in three states found that almost 1 in 4 low-income adults reported a change in coverage during the prior year, with half of those reporting a *gap* in coverage.[160] The study found significant disruptions of care for "churners," including a third reporting skipping doses or stopping taking prescribed medications[161] While not PrEP-specific, the study's findings raise concerns regarding PrEP adherence through coverage changes.

Providers whose PrEP patients lose Medicaid eligibility should be prepared to help navigate continuous access to PrEP medication and clinical services, whether under new insurance or through patient assistance programs and other funding streams. For example, one interviewee, a PrEP Navigator at a public health STD clinic, noted that she has helped people sign up for the Gilead patient assistance program as a stopgap when faced with interruptions in public or private insurance coverage.[162] Medicaid agencies could consider collaborating with public health agencies to develop resource guides that educate providers and patients on other sources of PrEP coverage if eligibility changes.

It is also important to note that in states with multiple Medicaid MCOs, beneficiaries could retain coverage but switch plans. Alignment across MCOs, including utilization management approaches and coverage policies for STI screening and other clinical services, would help smooth the transition for patients using PrEP.

Facilitating PrEP access for Medicaid-eligible people leaving the corrections system

Some people returning to the community after being incarcerated may be candidates for PrEP. Most states suspend, rather than terminate, Medicaid enrollment for individuals while they are incarcerated, in part to facilitate restarting coverage upon release.[163] The majority of states also have initiatives to facilitate Medicaid enrollment before release.[164] As part of the pre-release process, states can identify patients with heightened health or social needs. For example, Louisiana's state Medicaid agency begins planning nine months before release, and the process includes identification of "high needs" people such as those with serious mental illness, substance use disorder, or multiple morbidities.[165] States could explore whether Medicaid pre-release coordination processes in their state could address PrEP eligibility and include appropriate education and referrals.

Privacy for adolescent minors and other PrEP users in State Medicaid programs

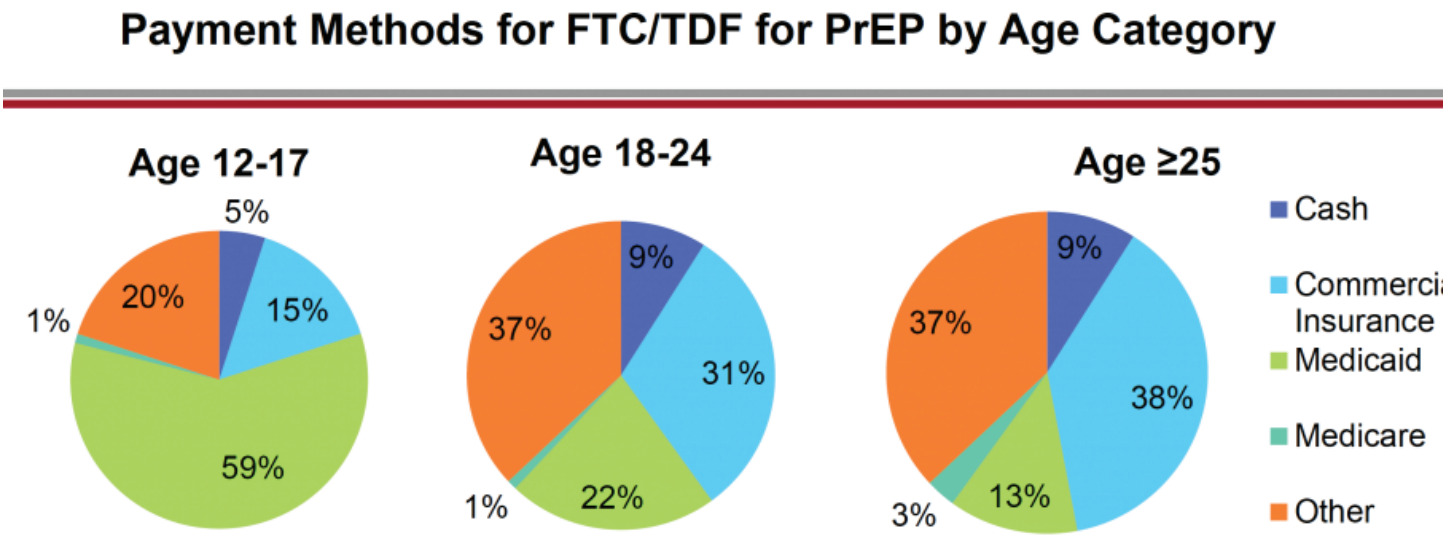
While Truvada has been used off-label for PrEP in adolescents prior to this year, FDA recently formally extended the drug's PrEP indication to adolescents weighing at least 35 kg (approx. 77 pounds).[166] A recently published study surveying a subset of members of the Society of Adolescent Health and Medicine found that a vast majority of respondents (93.2 percent) had heard of PrEP, and that 35.2 percent had prescribed it. However, overall young people are not accessing PrEP in proportion to the HIV risk experienced in this age group. Data presented by Gilead at the 2018 International AIDS Conference showed that 15 percent of people who had ever used Truvada were under age 25; only 1.5 percent were teenagers (and over 83 percent of the teenagers were girls).[167]

Among 12-17 year-olds, the data reflected that Medicaid was the most significant payer[168]:

PrEP as a Conduit to Medicaid or Other Insurance Coverage

To maximize Medicaid support of PrEP medication and clinical services, both clinical PrEP providers and non-clinical CBOs engaged in PrEP should engage in routine insurance screening and/or referral. Patients are not always aware of their eligibility for Medicaid, and these programs could help identify the eligible unenrolled. Insurance assistance could also help PrEP users navigate Medicaid administrative requirements to avoid gaps in coverage and access. Two interviewees noted that their intake processes for PrEP patients include counseling on Medicaid and other benefit eligibility as well as assistance with enrollment.[189,190]

A further reason for robust insurance assistance is that linking PrEP-eligible people to Medicaid or other insurance improves access to a broad range of services, including mental health and substance use disorder treatment services, further improving overall health and reducing HIV risk factors. In addition, identifying Medicaid-eligible people can help conserve funding in state and local PrEP assistance programs, such as those offered by Washington State,[191] New York State,[192] and Washington DC.[193]



Benefit-wise, since PrEP medication is approved for adolescents, Medicaid and CHIP programs should be expected to cover PrEP medication and clinical services for adolescents on the same terms as for adults. However, adolescent use can raise heightened questions about privacy. Federal law requires state Medicaid programs to have a process for confirming that beneficiaries in fact received the services billed. To comply with this requirement, some states send "explanation of benefit" (EOB) notices to beneficiaries after services are delivered, though this approach is not required. In addition, federal law requires Medicaid MCOs to send written notices of denials, or partial denials, of requests.

In a related issue for adolescents that is not Medicaid-specific, only some states' laws explicitly permit minors to independently consent to PrEP. The CDC's compilation of minor consent laws regarding HIV and STI services offers a starting point for state-level identification of any potential barriers for minor consent.[169]

State Medicaid agencies can identify how their EOB and privacy policies would apply to adolescents and other enrollees using PrEP and related services, and whether any suppression policy extends to denial notices. Pediatricians, adolescent health providers, and others who may offer PrEP or discuss it with adolescents should be made aware of what Medicaid privacy protections apply in their respective states.

PrEP and Substance Use

The key randomized trial of PrEP use among people who inject drugs, or PWID, found a reduction in HIV incidence of 49.8 percent compared to the placebo arm; for patient with high levels of adherence, the risk reduction was 73.5 percent.[170]

PWID may be willing to use PrEP but experience a range of barriers. Some studies have found extremely low rates of PrEP awareness among PWID in the US.[171] However, a number of studies have found fairly high *willingness* to use PrEP once information is shared. For example, in a study of PWID using a mobile syringe exchange service in Camden, NJ, 88.9 percent of women and 71.0 percent of men expressed willingness to use PrEP.[172] However, respondents also reported multiple barriers to PrEP use, including "feeling embarrassed (45.0%) or anxious (51.6%) about taking PrEP, nondisclosure to partners (51.4%), limited engagement with health care providers where PrEP might be provided (43.8%), and lacking health insurance (32.9%)."[173]

Meanwhile, substance use treatment providers may experience their own barriers to engaging in PrEP provision. For example, one study identified multiple barriers to PrEP provision among substance use treatment providers in six New York City outpatient programs.[174] At the time (2014), very few study respondents were aware of PrEP. Response was generally positive, but provider concerns about implementation included lack of medical staff to prescribe and monitor PrEP, questions about cost and reimbursement (including via Medicaid), and the need for training to help providers educate patients.[175] In addition, as noted by one interviewee, adherence concerns have historically led providers to hesitate to prescribe medication, such as ART or HCV treatment, to people who use drugs.[176]

Stakeholders could take a number of steps to explore the benefits and challenges of trying to improve access to PrEP medication and clinical services for people who inject drugs. A number of complex issues should be considered.[177]

- What do the epidemiologic data show in the state regarding people at high risk of HIV based on injection drug use? What about use of other drugs, which may impact sexual risk? What is the overlap of this group with Medicaid eligibility in the state?
- Are substance use treatment providers, including those offering medication-assisted treatment for opioid use, offering PrEP for prevention of sexual acquisition or of injection transmission in the case of relapse of injection drug use? Can or should these services be bundled with other SUD services?
- Are adequate syringe exchange programs (SEPs) currently in place? SEPs are highly effective at preventing the transmission of HIV by injection, as well as other viruses and bacteria. If an SEP is already providing high levels of HIV protection, what added level of risk protection, such as against sexual risk, would PrEP services offer? Are there other potential outreach approaches to reach people at risk of HIV who are *not* clients of SEPs? Could PrEP be instituted as an interim approach while SEPs are being established in the wake of significant HIV events in injection drug use, like the outbreak in Scott County, Indiana?
- How does injection drug use or the use of other drugs overlap with sexual risk factors for HIV? Among people with multiple risk factors, how many identify (internally or to their providers) as people who inject or use drugs? Would programs targeting PWID reach these populations?
- What is the ROI for PrEP for PWID? A 2016 study modeled evaluated the cost-effectiveness of providing adult U.S. PWID with PrEP, PrEP with frequent screening, and PrEP with ART for those who seroconvert.[178] The analysis found that the third scenario, PrEP + screening + ART, would offer the best outcome, averting 26,700 new infections.[179] However, it would cost $253,000 per QALY, compared to $4500-$34,000 per QALY in an SEP.[180]

Multiple interviewees noted that the current public health and political concern about the opioid epidemic is driving resources toward helping people who use drugs, including injection drugs. Therefore, to the extent stakeholders are interested in expanding PrEP access among people who inject or otherwise use drugs, they could identify opportunities for incorporating PrEP within and beyond the Medicaid program.

Conclusion

Scaling up the full PrEP intervention suite will require extensive patient and provider education and support efforts. As generic PrEP drugs and, potentially, long-acting injectables become available, the role of biomedical prevention will be even more important. The Medicaid program offers important opportunities to reach providers, as well as many of the patients who could most benefit from PrEP. The approaches outlined in this paper can serve as a starting point to identify next steps to seize these opportunities at the state level.

Appendix 1: Project Steering Committee

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Endnotes

1 Siegler AJ, et al., The prevalence of pre-exposure prophylaxis use and the pre-exposure prophylaxis to-need ratio in the fourth quarter of 2017, United States, Annals of Epidemiology (2018), https://doi.org/10.1016/j.annepidem.2018.06.005

2 CDC, "HIV prevention pill not reaching most Americans who could benefit – especially people of color" (Mar. 2018). www.cdc.gov/nchhstp/newsroom/2018/croi-2018-PrEP-press-release.html

3 See, e.g., California HIV/AIDS Research Program, "Addressing PrEP Disparities Among Young Gay and Bisexual Men in California" (Sep. 2016). https://apla-health.org/wp-content/uploads/2016/09/APLA_PrEP_FullReport_WEB.pdf

4 Goldstein et al., "Being PrEPared — Preexposure Prophylaxis and HIV Disparities." New England Journal of Medicine (Sept. 19, 2018). www.nejm.org/doi/full/10.1056/NEJMp1804306?query=TOC

5 Smith et al., "Estimates of adults with indications for HIV pre-exposure prophylaxis by jurisdiction, transmission risk group, and race/ethnicity, United States, 2015" Annals of Epidemiology xxx (2018) 1-8.

6 Huang et al., "HIV Preexposure Prophylaxis, by Race and Ethnicity — United States, 2014–2016." MMWR Morb Mortal Wkly Rep. 2018 Oct 19; 67(41): 1147–1150.

7 AIDSVU, "Deeper Look: PrEP." https://aidsvu.org/resources/deeper-look-prep/

8 Spinelli et al., "Provider Adherence to Pre-exposure Prophylaxis Monitoring Guidelines in a Large Primary Care Network" Open Forum Infectious Diseases, Volume 5, Issue 6, 1 June 2018, ofy099, https://doi.org/10.1093/ofid/ofy099

9 *Id.*

10 CDC, "PrEP" (Updated Aug. 23, 2018). www.cdc.gov/hiv/basics/prep.html

11 ANDA Approval Letter from FDA to Teva Pharmaceuticals USA, Inc. (June 8, 2017). www.accessdata.fda.gov/drugsatfda_docs/appletter/2017/090894Orig1s000ltr.pdf

12 *Id.*

13 CDC, "Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update: A Clinical Practice Guideline." " (Published online Mar. 2018). https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf

14 Nunn et al., "Defining the HIV pre-exposure prophylaxis care continuum." AIDS. 2017 Mar 13;31(5):731-734. doi: 10.1097/QAD.0000000ubach0000001385.

15 Strauss et al., "Exploring Patterns of Awareness and Use of HIV Pre-Exposure Prophylaxis Among Young Men Who Have Sex with Men." AIDS Behav. 2017 May;21(5):1288-1298. doi: 10.1007/s10461-016-1480-0.

16 Interview with Liz Hacker, October 5, 2018.

17 CDC, "HIV Among Youth." https://www.cdc.gov/hiv/group/age/youth/index.html.

18 Strauss et al., "Exploring Patterns of Awareness and Use of HIV Pre-Exposure Prophylaxis Among Young Men Who Have Sex with Men." AIDS Behav. 2017 May;21(5):1288-1298. doi: 10.1007/s10461-016-1480-0.

19 CDC, "HIV and Gay and Bisexual Men." https://www.cdc.gov/hiv/group/msm/index.html

20 CDC, "HIV Among Transgender People." https://www.cdc.gov/hiv/group/gender/transgender/index.html

21 Garnett et al., "Limited awareness of pre-exposure prophylaxis among black men who have sex with men and transgender women in New York City." AIDS Care. 2018 Jan;30(1):9-17. doi: 10.1080/09540121.2017.1363364. Epub 2017 Aug 9.

22 CDC, "HIV Among Women." https://www.cdc.gov/hiv/group/gender/women/index.html

23 Huang et al., "HIV Preexposure Prophylaxis, by Race and Ethnicity — United States, 2014–2016." MMWR Morb Mortal Wkly Rep. 2018 Oct 19; 67(41): 1147–1150.

24 Auerbach et al., "Knowledge, Attitudes, and Likelihood of Pre-Exposure Prophylaxis (PrEP) Use Among US Women at Risk of Acquiring HIV." AIDS Patient Care STDS. 2015 Feb 1; 29(2): 102–110.

25 Wood et al., "Young Transgender Women's Attitudes Toward HIV Pre-Exposure Prophylaxis." J Adolesc Health. (2017) May; 60(5): 549–555.

26 Auerbach et al., "Knowledge, Attitudes, and Likelihood of Pre-Exposure Prophylaxis (PrEP) Use Among US Women at Risk of Acquiring HIV." AIDS Patient Care STDS. 2015 Feb 1; 29(2): 102–110.

27 Interview with Kristin Keglovitz-Baker and Chad Hendry, September 27, 2018.

28 Data.Medicaid.Gov, "National Average Drug Acquisition Cost" Database. https://data.medicaid.gov/Drug-Pricing-and-Payment/NADAC-National-Average-Drug-Acquisition-Cost-/a4y5-998d

29 Guerrero, "Myth Busted! PrEP Does Not Lower HRT Levels In Trans Women." Plus (July 30, 2018). https://www.hivplusmag.com/prevention/2018/7/30/myth-busted-prep-does-not-lower-hrt-trans-women

30 Hiransuthikul et al., "Drug-drug interactions between the use of feminizing hormone therapy and pre-exposure prophylaxis among transgender women: The iFACT study." Presented at the 22nd International AIDS Conference (2018). https://programme.aids2018.org//PAGMaterial/eposters/13177.pdf

31 See also Hubach et al., "Barriers to and Adoption of Pre-Exposure Prophylaxis for the Prevention of HIV Among Men Who Have Sex with Men (MSM) in a Relatively Rural State" AIDS Education and Prevention, 29(4), 315–329, 2017.

32 Interview with Liz Hacker, October 5, 2018.

33 Hubach et al., "Barriers to and Adoption of Pre-Exposure Prophylaxis for the Prevention of HIV Among Men Who Have Sex with Men (MSM) in a Relatively Rural State" AIDS Education and Prevention, 29(4), 315–329, 2017.

34 Interview with Liz Hacker, October 5, 2018.

35 Seidman et al., "Family planning providers' role in offering PrEP to women." Contraception 97 (2018) 467–470.

36 Maloney et al., "Culturally Competent Sexual Healthcare as a Prerequisite for Obtaining Preexposure Prophylaxis: Findings from a Qualitative Study." LGBT Health (2017); Volume 4, Number 7.

37 Cahill et al., "Stigma, medical mistrust, and perceived racism may affect PrEP awareness and uptake in black compared to white gay and bisexual men in Jackson, Mississippi and Boston, Massachusetts." AIDS Care. 2017 Nov; 29(11): 1351–1358.

38 Eaton et al., "Stigma and Conspiracy Beliefs Related to Pre-exposure Prophylaxis (PrEP) and Interest in Using PrEP Among Black and White Men and Transgender Women Who Have Sex with Men." AIDS Behav. 2017 May; 21(5): 1236–1246.

39 Calabrese et al., "HIV Pre-Exposure Prophylaxis Stigma as a Multidimensional Barrier to Uptake Among Women Who Attend Planned Parenthood." JAIDS: September 1, 2018 - Volume 79 - Issue 1 - p 46–53doi: 10.1097/QAI.0000000000001762.

40 *Id.*

41 Blackstock et al., "A Cross-Sectional Online Survey of HIV Pre-Exposure Prophylaxis Adoption Among Primary Care Physicians" J Gen Intern Med (2016) 32(1):62–70.

42 Blumenthal et al., "Knowledge is Power! Increased Provider Knowledge Scores regarding Pre-exposure Prophylaxis (PrEP) are Associated with Higher Rates of PrEP Prescription and Future Intent to Prescribe PrEP." AIDS Behav. 2015 May ; 19(5): 802–810. doi:10.1007/s10461-015-0996-z.

43 Petroll et al., "PrEP Awareness, Familiarity, Comfort, and Prescribing Experience among US Primary Care Providers and HIV Specialists." AIDS Behav. 2017 May ; 21(5): 1256–1267. doi:10.1007/s10461-016-1625-1.

44 Clement et al., "An educational initiative in response to identified PrEP prescribing needs among PCPs in the Southern U.S.," AIDS Care, 30:5,650-655, DOI: 10.1080/09540121.2017.1384534.

45 Petroll et al., "PrEP Awareness, Familiarity, Comfort, and Prescribing Experience among US Primary Care Providers and HIV Specialists." AIDS Behav. 2017 May ; 21(5): 1256–1267. doi:10.1007/s10461-016-1625-1.

46 Interview with Donna Sweet, August 16, 2018.

47 *Id.*

48 Interview with Erin Loubier, Juan Carlos Loubriel, and Megan Coleman, August 7, 2018.

49 Interview with Sarah Calabrese, August 21, 2018.

50 Calabrese, Krakower, and Mayer, "Integrating HIV Preexposure Prophylaxis (PrEP) Into Routine Preventive Health Care to Avoid Exacerbating Disparities." American Journal of Public Health December 2017, Vol 107, No. 12.

51 Interview with Doug Krakower, August 9, 2018.

52 Blumenthal et al., "Knowledge is Power! Increased Provider Knowledge Scores regarding Pre-exposure Prophylaxis (PrEP) are Associated with Higher Rates of PrEP Prescription and Future Intent to Prescribe PrEP." AIDS Behav. 2015 May ; 19(5): 802–810. doi:10.1007/s10461-015-0996-z.

53 Wood et al., "Knowledge, Practices, and Barriers to HIV Preexposure Prophylaxis Prescribing Among Washington State Medical Providers." Sexually Transmitted Diseases (July 2018) Volume 45, Number 7.

54 Blackstock et al., "A Cross-Sectional Online Survey of HIV Pre-Exposure Prophylaxis Adoption Among Primary Care Physicians" J Gen Intern Med (2016) 32(1):62–70.

55 Calabrese et al., "Putting PrEP into Practice: Lessons Learned from Early-Adopting U.S. Providers' Firsthand Experiences Providing HIV Pre-Exposure Prophylaxis and Associated Care. PLoS ONE (2016) 11(6): e0157324. doi:10.1371/journal.pone.0157324

56 See, e.g., Wood et al., "Knowledge, Practices, and Barriers to HIV Preexposure Prophylaxis Prescribing Among Washington State Medical Providers." Sexually Transmitted Diseases (July 2018) Volume 45, Number 7.

57 Krakower et al., "HIV Providers' Perceived Barriers and Facilitators to Implementing Pre-Exposure Prophylaxis in Care Settings: A Qualitative Study." AIDS Behav. 2014 September ; 18(9): 1712–1721. doi:10.1007/s10461-014-0839-3

58 Interview with Gretchen Weiss, August 17, 2018.

59 Hoover et al., "Human Immunodeficiency Virus Prevention With Preexposure Prophylaxis in Sexually Transmitted Disease Clinics." Sexually Transmitted Diseases Volume 43, Number 5, May 2016.

60 See, e.g., Interview with Doug Krakower, August 9, 2018; interview with Donna Sweet, August 16, 2018.

61 Interview with John Carlo, August 6, 2018.

62 Calabrese et al., "A Closer Look at Racism and Heterosexism in Medical Students' Clinical Decision-Making Related to HIV Pre-Exposure Prophylaxis (PrEP): Implications for PrEP Education." AIDS and Behavior (2018) 22:1122–1138. https://doi.org/10.1007/s10461-017-1979-z

63 Calabrese et al., "The Impact of Patient Race on Clinical Decisions Related to Prescribing HIV Pre-Exposure Prophylaxis (PrEP): Assumptions About Sexual Risk Compensation and Implications for Access." AIDS Behav. (2014) February; 18(2): 226–240. doi:10.1007/s10461-013-0675-x.

64 Raifman et al., "Healthcare Provider Contact and Pre-exposure Prophylaxis in Baltimore Men Who Have Sex With Men" Am J Prev Med. 2017 January; 52(1): 55–63. doi:10.1016/j.amepre.2016.07.031.

65 Hubach et al., "Barriers to and Adoption of Pre-Exposure Prophylaxis for the Prevention of HIV Among Men Who Have Sex with Men (MSM) in a Relatively Rural State" AIDS Education and Prevention, 29(4), 315–329, 2017.

66 See, e.g., District of Columbia Department of Health, "Explore your Options: PrEP." https://doitrightdc.com/prep/prep-locator/

67 North Carolina AIDS Education and Training Center, "Consumers Interested in or Currently Taking PrEP." https://www.med.unc.edu/ncaidstraining/clinician-resources/prep/prep-for-consumers/

68 CDC, "Prescribe HIV Prevention." https://www.cdc.gov/actagainstaids/campaigns/prescribe-hiv-prevention/index.html

69 D.C. Department of Health, "PrEP Handbook: PrEP is DC's Key HIV Prevention Practice." https://doh.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/DC%20Providers%20PrEP%20Handbook.pdf

70 Interview with Melody Wilkinson, August 22, 2018.

71 Interview with Kristin Keglovitz-Baker and Chad Hendry, September 27, 2018.

72 See, e.g., SIECUS, "PrEP Education for Youth-Serving Primary Care Providers Toolkit: Clinical Tools Section 1.7: Taking A Sexual History" (2018) https://siecus.org/wp-content/uploads/2018/07/1.7-Taking-A-Sexual-History.pdf

73 Decker, "Academic detailing as an intervention to increase PrEP knowledge and best prescribing practices among providers in San Francisco" (July 20, 2017). www.nastad.org/sites/default/files/Mega-Meeting-Slides/opportunities_to_engage_clinical_providers_-_alyson_decker.pdf

74 AcademyHealth Interview with Deann Gruber, May 23, 2018.

75 AcademyHealth interview with Lyn Stevens, June 5, 2018.

76 Interview with Player and Diaz, August 28, 2018.

77 *Id.*

78 Interview with Sarah Calabrese, August 21, 2018.

79 Interview with Melody Wilkinson, August 22, 2018.

80 New York State Department of Health AIDS Institute, "Clinical Education Initiative" www.surveymonkey.com/r/BG38MH5.

81 Interview with Sarah Calabrese, August 21, 2018.

82 Interview with Liz Hacker, October 5, 2018.

83 Liu et al., "Randomized Controlled Trial of a Mobile Health Intervention to Promote Retention and Adherence to Preexposure Prophylaxis Among Young People at Risk for Human Immunodeficiency Virus: The EPIC Study," Clinical Infectious Diseases (2018). https://doi.org/10.1093/cid/ciy810

84 Email from Pedro Serrano, Oct. 26, 2018.

85 Interview with Player and Diaz, August 28, 2018.

86 Interview with Bellinda Schoof, August 29, 2018.

87 CDC, "Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update – Clinical Providers' Supplement" (Published online Mar. 2018). www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-provider-supplement-2017.pdf

88 The Stigma Project, www.ispreprightforme.org.

89 Amico et al., "Integrated Next Step Counseling (iNSC) for Sexual Health and PrEP Use Among Young Men Who Have Sex with Men: Implementation and Observations from ATN110/113." AIDS Behav (2018). https://doi.org/10.1007/s10461-018-2291-2

90 UCSF Clinical Consultation Center, "PrEP: Pre-Exposure Prophylaxis" (2018). Available at https://nccc.ucsf.edu/clinician-consultation/prep-pre-exposure-prophylaxis/

91 AETC National Coordinating Resource Center, "Directory of AIDS Education and Training Centers" (2018). https://aidsetc.org/directory

92 Interview with Erin Loubier, Juan Carlos Loubriel, and Megan Coleman, August 7, 2018.

93 Interview with Douglas Krakower, August 8, 2018.

94 Interview with Diva Ahuja, August 9, 2018.

95 Interview with Stephen Cha, August 6, 2018; www.medicaid.gov/federal-policy-Guidance/index.html

96 CMS, "Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries" (Dec. 2016). www.medicaid.gov/federal-policy-guidance/downloads/cib120116.pdf

97 CMS, "Medicaid.gov: Substance Use Disorder Tools & Resources." www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/tools-and-resources/index.html

98 AcademyHealth survey of MMDN, October 2018.

99 *Id.*

100 California Department of Health Care Services, "DUR: Educational Articles" http://files.medi-cal.ca.gov/pubsdoco/dur/edarticles.asp

101 New York State Department of Health, "DOH Medicaid Update." www.health.ny.gov/health_care/medicaid/program/update/main.htm

102 AcademyHealth survey of MMDN, October 2018.

103 Interview with Doug Wirth, September 17, 2018.

104 *Id.*

105 Interview with David Rzeszutko, August 14, 2018.

106 AcademyHealth survey of MMDN network, October 2018.

107 Interview with Stephen Cha, August 6, 2018.

108 National Medical Association, "About Us." https://www.nmanet.org/page/About_Us

109 National Hispanic Medical Association, "About NHMA." http://www.nhmamd.org/about/about-nhma/

110 American College of Physicians, "About ACP." https://www.acponline.org/about-acp

111 AMA, "AMA Urges More Physician Education on Use of Once-A-Day HIV Prevention" (June 2016). www.ama-assn.org/ama-urges-more-physician-education-use-once-day-hiv-prevention

112 *Id.*

113 AMA, "Member Groups (Sections)." www.ama-assn.org/about/member-groups-sections

114 AMA, "AMA Federation Directory." https://federationdirectory.ama-assn.org/federations

115 AAFP, "Family Medicine Facts." www.aafp.org/about/the-aafp/family-medicine-facts.html

116 AAFP, "Table 1: 2018 AAFP Membership Category" www.aafp.org/about/the-aafp/family-medicine-facts/table-1.html

117 AAFP, "Prevention and Control of Sexually Transmitted and Blood Borne Infections" (2016). www.aafp.org/about/policies/all/prevention-control.html

118 Interview with Bellinda Schoof, August 29, 2018.

119 Interview with Melody Wilkinson, August 22, 2018.

120 AAFP, "Browse Directory." https://my.aanp.org/Directories/BrowseBy.aspx

121 Interview with Gretchen Weiss, August 17, 2018.

122 Interview with Leighton Ku, September 5, 2018.

123 For example, the State-University Partnership Learning Network (SUPLN) fosters collaboration between state governments and state university research centers to conduct research on the Medicaid program. https://www.academyhealth.org/SUPLN.

124 Interview with Leighton Ku, September 5, 2018.

125 *Id.*

126 Interview with Doug Wirth, September 17, 2018.

127 To distinguish between PrEP and post-exposure prophylaxis, which involves 28 days of medication.

128 Laufer et al., "Vital Signs: Increased Medicaid Prescriptions for Preexposure Prophylaxis Against HIV infection — New York, 2012–2015." MMWR November 27, 2015 / 64(46);1296-1301. www.cdc.gov/mmwr/preview/mmwrhtml/mm6446a5.htm

129 California HIV/AIDS Policy Research Centers. Examining PrEP Uptake among Medi-Cal Beneficiaries in California: Differences by Age, Gender, Race/Ethnicity and Geographic Region (Feb. 2018). http://www.californiaaidsresearch.org/files/PrEP_Brief_2.8.18.pdf

130 Smith et al., "Estimates of adults with indications for HIV pre-exposure prophylaxis by jurisdiction, transmission risk group, and race/ethnicity, United States, 2015" Annals of Epidemiology xxx (2018) 1-8.

131 Email from Pedro Serrano, Oct. 26, 2018.

132 Interview with Leighton Ku, September 5, 2018.

133 NASTAD, "Modernizing Programs to Collect Sexual Orientation and Gender Identity Data." www.nastad.org/sites/default/files/sogi.issue_.brief_.final_.pdf

134 Interview with Doug Krakower, August 8, 2018.

135 Interview with Leighton Ku, September 5, 2018.

136 AcademyHealth Interview with Michigan officials, May 24, 2018.

137 Center for Connected Health Policy, "50 State Scan of Telehealth Reimbursement Laws and Medicaid Policies – Factsheet" (2018). www.cchpca.org/sites/default/files/resources/50%20State%20Factsheet%20Spring%202018%20FINAL.pdf

138 *Id.*

139 Kaiser Family Foundation, Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans" (Mar. 2018). www.kff.org/report-section/medicaid-managed-care-plans-and-access-to-care-provider-networks-and-access-to-care/

140 Peter Wehrwein, "Q&A: A Conversation with Henry DePhillips, MD: The Doctor in the Teladoc House" (April 2017). www.managedcaremag.com/archives/2017/4/conversation-henry-dephillips-md-doctor-teladoc-house

141 AcademyHealth interview with Lyn Stevens, June 5, 2018.

142 AcademyHealth Interview with Deann Gruber, May 23, 2018; www.louisianahealthhub.org/teleprep

143 Interview with Jason Farley, August 9, 2018.

144 NASTAD, "Financing HIV Prevention Services: Collaboration and Innovation between Public Health and Medicaid Agencies; Case Study: Rhode Island" (Feb. 2016). www.nastad.org/sites/default/files/resources/docs/NASTAD-HIV-Prevention-Rhode-Island-Case-Study.pdf

145 Interview with Erin Loubier, Juan Carlos Loubriel, and Megan Coleman, August 7, 2018.

146 42 CFR 431.53 - Assurance of transportation.

147 Mayer et al., "Evolving Models and Ongoing Challenges for HIV Preexposure Prophylaxis Implementation in the United States" J Acquir Immune Defic Syndr (2018);77:119–127.

148 National Conference of State Legislatures, "Medication Therapy Management: Pharmaceutical Safety and Savings" (Updated Oct. 2016). http://www.ncsl.org/research/health/medication-therapy-management.aspx

149 Mississippi Division of Medicaid, "Mississippi Medicaid Provider Reference Guide: Part 214: Pharmacy Services" (2014). https://medicaid.ms.gov/wp-content/uploads/2014/01/Provider-Reference-Guide-214.pdf

150 Interview with Elyse Tung, September 7, 2018.

151 *Id.*

152 *Id.*

153 Interview with Laura Beauchamps, August 16, 2018.

154 Interview with Elyse Tung, September 7, 2018.

155 Interview with Laura Beauchamps, August 16, 2018.

156 Interview with Player and Diaz, August 28, 2018.

157 *Id.*

158 42 CFR § 440.262 Access and cultural considerations.

159 42 CFR 438.206 - Availability of services.

160 Sommers et al., "Insurance Churning Rates For Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful For Many." Health Affairs 35, No. 10 (2016).

161 *Id.*

162 Interview with Liz Hacker, October 5, 2018.

163 Kaiser Family Foundation, "Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018" (Oct. 2017). http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018

164 *Id.*

165 *Id.*

166 Letter from FDA to Gilead (May 15, 2018). www.accessdata.fda.gov/drugsatfda_docs/appletter/2018/021752Orig1s055ltr.pdf

167 Ryan, "Just 15% of Those Who've Started PrEP Are Younger Than 25." Poz (July 30, 2018). www.poz.com/article/just-15-whove-started-prep-younger-25

168 Data from Gilead, reproduced in Ryan, "Just 15% of Those Who've Started PrEP Are Younger Than 25." Poz (July 30, 2018). https://www.poz.com/article/just-15-whove-started-prep-younger-25

169 CDC, "Minors' Consent Laws for HIV and STI Services" (Updated June 2018). www.cdc.gov/hiv/policies/law/states/minors.html

170 Choopanya et al. "Antiretroviral prophylaxis for HIV infection in injecting drug users in Bangkok, Thailand (the Bangkok Tenofovir Study): A randomised, double-blind, placebo-controlled phase 3 trial." Lancet 2013; 381:2083–2090.

171 See, e.g., Stein et al., "Willingness to use HIV pre-exposure prophylaxis among opiate users" AIDS Behav (2014); 18:1694–1700; finding PrEP awareness of 7.4 percent among opioid users entering detox.

172 Roth et al., "An Exploration of Factors Impacting Preexposure Prophylaxis Eligibility and Access Among Syringe Exchange Users." Sexually Transmitted Diseases (April 2018) 45: 4.

173 *Id.*

174 Spector et al.," PrEP in substance abuse treatment: a qualitative study of treatment provider perspectives." Substance Abuse Treatment, Prevention, and Policy (2015) 10:1. www.substanceabusepolicy.com/content/10/1/1

175 *Id.*

176 Interview with Daniel Raymond, October 4, 2018.

177 *Id.*

178 Bernard et al., "Cost-Effectiveness of HIV Preexposure Prophylaxis for People Who Inject Drugs in the United States." Ann Intern Med. ;165:10–19.

179 *Id.*

180 *Id.*

181 See https://grants.nih.gov/grants/guide/rfa-files/rfa-ai-16-031.html

182 Interview with Sarah Calabrese, August 21, 2018; Walsh and Petroll, "Factors Related to Pre-exposure Prophylaxis Prescription by U.S. Primary Care Physicians." Am J Prev Med 2017 Jun;52(6).

183 Chartier et al., "Accessibility and Uptake of Pre-Exposure Prophylaxis for HIV Prevention in the Veterans Health Administration." Fed Pract. 2018 March;35(2):S42-S48.

184 *Id.*

185 California Department of Health Care Services, "Erroneous Treatment Delays and Denials for HIV PrEP and PEP" (Dec. 11, 2017). http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_26539.asp.

186 New York State Department of Health, "Truvada (emtricitabine and tenofovir DF) Medicaid Fee-for-Service." www.health.ny.gov/diseases/aids/general/prep/truvada.htm

187 Interview with Leighton Ku, September 5, 2018.

188 NMAC, HIV and PrEP Navigation Program: Linking Communities to Care through HIV and PrEP Navigation. www.nmac.org/programs/capacity-building/hiv-prep-navigation-program/

189 Interview with Laura Beauchamps, August 16, 2018.

190 Interview with Liz Hacker, October 5, 2018.

191 Washington State Department of Health, "Pre-Exposure Prophylaxis Drug Assistance Program (PrEP DAP)." www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/Prevention/PrEPDAP

192 New York State Department of Health, "PrEP Patient Assistance Program (PrEP-AP)." www.health.ny.gov/diseases/aids/general/prep/prep-ap_provider.htm

193 DC Department of Health, "Pre Exposure Prophylaxis Drug Assistance Program (PrEP DAP)." https://dchealth.dc.gov/DCPrEPDAP

AcademyHealth

Leveraging Financing and Coverage Benefits: Medicaid Strategies to Deliver PrEP Intervention Services

Prepared for the CDC, ChangeLab and AcademyHealth as part of the Medicaid Strategies to Implement Comprehensive PrEP Intervention Services project

Naomi Seiler, JD

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Thank you to all of the experts who participated in interviews for this project, as well as to those who generously reviewed a draft of this white paper: Sean Bland and Jeffrey Crowley at the O'Neill Institute at Georgetown Law; Jennifer Kates at the Kaiser Family Foundation; and Amy Killilea at the National Association of State and Territorial AIDS Directors. Any mistakes or omissions are the author's.

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Introduction

Pre-exposure prophylaxis, or PrEP, is a highly effective HIV prevention intervention that is dramatically underused, with one recent analysis suggesting that fewer than 1 in 10 people with indications for PrEP in the U.S. are receiving it.[1] Use of PrEP is disproportionately low among African American and Latinx people, as well as lower-income populations.[2,3,4] Between 2015 and 2016, an estimated 1.14 million Americans were eligible for PrEP, but only 90,000 PrEP prescriptions were filled; only 1 percent of eligible African Americans and 3 percent of eligible Latinos were using PrEP, compared to 14 percent of eligible Whites.[5] Among those who do use PrEP, evidence indicates that some may not be receiving the full set of PrEP clinical services as recommended by the Centers for Disease Control and Prevention (CDC) – such as HIV screening before initiation and quarterly, multisite STI screenings.[6]

As part of its work to address these challenges, the CDC is supporting a project, led by AcademyHealth and ChangeLab, to identify ways to improve care and delivery of PrEP medication and clinical services to the Medicaid population. Medicaid's role as insurance for low-income Americans – particularly since the Medicaid expansions authorized under the Affordable Care Act – makes the program a crucial vehicle for expanding access.

To inform this project, this white paper identifies Medicaid benefits and financing mechanisms that could be used to improve uptake and comprehensive delivery of PrEP medication and clinical care. A second white paper describes further ways to leverage the Medicaid program to engage patients and providers in accessing PrEP and utilizing the full suite of recommended PrEP clinical services. The papers will inform a ChangeLab/AcademyHealth convening of Medicaid officials from select states, representatives of managed care organizations (MCOs), public health officials, and patient and provider stakeholders in January of 2019 to consider which of the approaches discussed may be appropriate for their policy environments.

This paper begins with background information on PrEP and PrEP recommended services and on Medicaid, including the current status of state Medicaid expansions and an overview of models and penetration rates of managed care in Medicaid programs.

It then presents a framework for considering the "levers" in the Medicaid program that could be used to increase and improve PrEP delivery:

- **State-level financial policies** that can impact PrEP care, including MCO rate-setting and carveouts, as well as other managed care and value-based design approaches;
- **Benefit design** related to PrEP medication and clinical services, including benefits covered by the state's fee-for-service program, additional benefits that MCOs can offer, contract approaches to aligning benefits across fee-for-service (FFS) and managed care, and the potential impact of the U.S. Preventive Services Task Force (USPSTF) draft recommendation for PrEP;
- **Performance improvement**, based on reporting or incentives at the plan and provider levels;
- **Access to PrEP providers** in managed care Medicaid, as shaped by state policies on network adequacy and on MCO network decisions; and
- **Partnerships** with local health departments or community-based organizations (CBOs), and how states and MCOs can identify and support them.

The paper continues with an overview of Medicaid financing issues for PrEP that are specific to certain types of providers and settings: nurse practitioners and physician assistants, registered nurses (RNs), pharmacists, and federally-qualified and rural health centers. It closes with a discussion of two key overarching considerations: the potential uses of Medicaid claims data to support the use of PrEP medication and clinical care, and the importance of information on PrEP's return on investment (ROI) to effect change within the Medicaid program – at the state level or with specific MCOs.

Every state differs in its HIV epidemic, its resources, its Medicaid program, and the relationship between the HIV/public health community and the Medicaid agency. This paper does not present a one-size-fits-all answer to improving PrEP access through Medicaid. Rather, the goal is to outline in one place the potential tools that state-level stakeholders could use to identify and address barriers in their states, taking into account fiscal and political feasibility. Table 1 contains a high-level summary of issues to consider at the state level, based on the topics covered in this paper. After the convening in January 2019, condensed versions of the white papers will be developed as an additional tool to help stakeholders at the state level identify key action items.

Table 1: High-Level Issues to Consider at the State Level

Medicaid Landscape
What categories of Medicaid eligibility in the state are available to people who are using or are candidates for PrEP?

Has the state expanded Medicaid, facilitating access for a broad set of low-income adults?

Does the state have a Medicaid family planning expansion program, which may facilitate access to some PrEP medication or clinical care services such as sexually transmitted infections (STIs) and HIV screening?

What role do comprehensive MCOs play in the state's Medicaid landscape?

State Level Financial Policies
How can current and projected PrEP uptake be meaningfully reflected in the rates that states pay Medicaid MCOs as well as in the risk-adjustment formula applied?

Is the medication for PrEP carved out of the state's managed care contracts, and if so, how does this influence access to medication and clinical services?

Should the state consider carving the full set of PrEP services out of managed care?

Are there innovative payment models in the state Medicaid program, such as Medicaid health homes, accountable care organizations (ACOs), or others, that could be used or modified to support PrEP?

Benefit Design
What is the state's policy on Medicaid coverage of telehealth, and how might it affect access to and use of PrEP clinical care?

Does the state's Medicaid FFS program apply limits, such as prior authorization requirements, to medication for PrEP? Are they aligned with PrEP care requirements such as confirming ongoing negative serostatus, or do they pose inappropriate barriers to access?

Does the state FFS program pay consistently for PrEP clinical services, including multisite STI testing, as recommended by the CDC?

Does the state FFS program cover optional benefits that could be used to support PrEP, such as targeted case management?

Beyond the benefits in the state Medicaid package, do Medicaid MCOs offer additional services that are relevant to PrEP, such as care coordination services? If so, is PrEP a qualifying condition? Can and should it be?

What approaches can the state use to align coverage policies for PrEP medication and clinical services across the FFS program and MCOs?

Performance Improvement
What programs does the state have to monitor and reward MCO performance, and how could PrEP measures be integrated?

Does the state have a system for performance incentives to Medicaid FFS providers that could be leveraged to support comprehensive PrEP services?

Can support and incentives for offering PrEP clinical services be integrated into existing MCO provider payment models, such as performance incentives or bundled payments? How?

Access to PrEP Providers
How can the state assess the availability of PrEP providers in the Medicaid FFS program?

Are Medicaid MCOs in the state including PrEP providers in their networks? How can the state and MCOs work together to assess and track PrEP provider access?

Partnerships with Local Health Departments and Community-Based Organizations
How could the state Medicaid agency work with local health departments and CBOs to promote use of PrEP medication and clinical services?

Could the state require or encourage MCOs to work with local health departments, CBOs or community health workers to promote use of PrEP medication and clinical services? If so, what would this look like?

Specific Considerations Linked to Provider Type and Setting
Are nurse practitioners and physician assistants who provide PrEP able to bill Medicaid for all components of the intervention?

How can the state Medicaid program better support pharmacist engagement in PrEP medication management and clinical service delivery, including through a state Medication Therapy Management (MTM) benefit?

Are public/local health department clinics able to bill Medicaid if they offer PrEP?

Do the state's Medicaid reimbursement rates for Federally-Qualified Health Centers and Rural Health Centers adequately support and incentivize comprehensive provision of PrEP?

Further Considerations
How can Medicaid and public health use existing data to evaluate PrEP access and PrEP uptake, as well as the quality of PrEP care?

What kinds of cost information do Medicaid and MCOs need to inform design of PrEP benefits and delivery?

Table 2: Experts Interviewed for the Project

Divya Ahuja, MD, University of South Carolina Associate Professor of Clinical Internal Medicine

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Melody Wilkinson, DNP, APRN, FNP-BC, Member, American Association of Nurse Practitioners (AANP); Program Director of the Family Nurse Practitioner Program and Assistant Professor, Georgetown University

Doug Wirth, MSW, President and CEO, Amida Care (NY)

Mike Wofford, PharmD, Chief Medi-Cal Pharmacy Policy, CA Department of Healthcare Services

** Interviewed by AcademyHealth staff in preliminary interviews*

Methodology

AcademyHealth conducted initial discussions with the project Steering Committee (see Appendix 1) to identify the appropriate scope for this white paper. AcademyHealth staff then conducted preliminary interviews with a set of key informants to begin to develop key themes and topics for the convening and white papers (see Table 2; preliminary interviews conducted by AcademyHealth are marked with an asterisk).

The author then conducted semi-structured interviews with additional experts in Medicaid, PrEP, and patient and provider engagement (see Table 2). Interviews of multiple staff at the same organization or agency were combined.

All interviews were conducted for the overall project, with insights from the experts incorporated into both white papers.

The author also conducted a search of peer-reviewed and "grey" literature on Medicaid and PrEP, as well as on Medicaid financing mechanisms.

AcademyHealth conducted an informal survey of the participants in its Medicaid Medical Directory Network (MMDN) regarding their Medicaid coverage of PrEP medication and clinical care, as well as provider and patient engagement. De-identified responses from 16 states are included in this and the second white paper.

Background

PrEP and the CDC's Guidelines

Pre-exposure prophylaxis for HIV, or PrEP, refers to the daily use of a medication by people who are HIV-negative to reduce the risk of seroconversion. Trials have demonstrated effectiveness of over 90 percent for consistent use among those at risk of sexual transmission, and over 70 percent for people who inject drugs.[7] This section outlines the components of the full suite of PrEP services, as well as the populations for whom it is indicated, as context for the discussion of the scope and limitations of Medicaid coverage of PrEP.

There is only one drug currently approved by the FDA for PrEP in the US: a fixed-dose combination of tenofovir disoproxil fumarate (TDF) 300 mg and emtricitabine (FTC) 200 mg, sold by Gilead as Truvada. All states must cover Truvada for PrEP in their Medicaid programs, but there is variation across and within states in whether barriers to access exist. The FDA granted ANDA approval to Teva[8] and Amneal[9] for generic versions of Truvada in June 2017 and August 2018, respectively. However, neither has yet become available on the U.S. market.

The CDC recommends PrEP be considered as one prevention option for the following people at substantial risk of HIV infection[10]:

Men Who Have Sex with Men (MSM) (including those who inject drugs)

- HIV-positive sexual partner
- Recent bacterial STI (gonorrhea, chlamydia, syphilis)
- High number of sex partners
- History of inconsistent or no condom use
- Commercial sex work

Persons Who Inject Drugs

- HIV-positive injecting partner
- Sharing injection equipment

Heterosexual Women and Men (including those who inject drugs)

- HIV-positive sexual partner
- Recent bacterial STI (gonorrhea, syphilis)
- High number of sex partners
- History of inconsistent or no condom use
- Commercial sex work
- In high HIV prevalence area or network

In order to determine clinical eligibility, the guidelines recommend a documented negative HIV test result; an assessment to rule out signs or symptoms of acute HIV infection; a renal function test (estimated creatinine clearance); and assessment of current medications to rule out contraindications. While not a clinical eligibility criterion, documentation of Hepatitis B infection and vaccination status is recommended prior to initiating PrEP. The CDC recommends that once on PrEP, people receive a follow-up visit at least quarterly for an HIV test, medication adherence counseling, behavioral risk reduction support, side effect assessment, and STI symptom assessment. Renal function testing is recommended at 3 months and every 6 months thereafter. Overall, bacterial STI testing is recommended every 3-6 months for both sexually active men and women. The CDC recommends nucleic acid amplification (NAAT) STI testing at sites of potential sexual exposure including pharyngeal and rectal testing for MSM, as well as rectal testing for women who report engaging in anal sex. Providers should offer pregnancy tests and discussion of pregnancy intent with women every six months, and people who inject drugs should have access to clean needles and drug treatment services.

The discussions of state Medicaid benefits and of Medicaid MCO coverage policies below review key opportunities for, and barriers to, coverage of this set of services.

The Range of Medicaid Policy and Program Environments

Most elements of the Medicaid program – including eligibility, benefits, and financing mechanisms – vary significantly from state to state. This section describes the range of Medicaid policy and program environments, with an emphasis on those features that are relevant to the coverage of PrEP medication and clinical services.

Low-income uninsured patients who do not qualify for Medicaid may be able to access Truvada through the manufacturer's assistance program, which currently offers eligibility up to 500 percent of the federal poverty level for U.S. residents.[11] However, people without insurance may not have a source of assistance to cover PrEP clinical care services and laboratory tests. State and local PrEP assistance programs, such as those offered by Washington State,[12] New York State,[13] and Washington DC,[14] could help fill these gaps but are not widely offered.

Medicaid Eligibility

Eligibility for Medicaid for various populations eligible for PrEP depends on the state and is based on age, household income, and other demographic factors.

Eligibility Categories

Adolescents and pregnant women may be candidates for PrEP; both populations are eligible for Medicaid in all states. In all but two states, children and adolescents through age 18 are eligible for coverage, either through Medicaid or CHIP, up to income levels of at least 200 percent of the federal poverty level (FPL).[15] Approximately two-thirds of states (33 plus DC) cover pregnant women with income levels up to 200 percent FPL or higher; the remainder set eligibility for pregnant women between 138-200 percent of FPL.[16] People with disabilities who are Supplemental Security Income (SSI) beneficiaries are eligible up to thresholds of at least 73 percent in most states.[17]

If a candidate for PrEP is the parent of dependent children, Medicaid may be available, but the income cutoff is quite low in the 19 states that have not expanded Medicaid: in 11 of the 19 non-expansion states, eligibility for parents of dependent children is set lower than 50 percent of the FPL.

Overall, "lawfully present" immigrants may be eligible for Medicaid depending on income level, but in most states non-pregnant adults face a five-year waiting period after obtaining qualified status; in roughly half the states, children and pregnant women face the same waiting period.[18] For the most part, undocumented immigrants are not eligible for Medicaid, other than through a narrow set of exceptions that would not be relevant for most PrEP users.[19] U.S. residents are currently eligible for the manufacturer's assistance program for Truvada, regardless of citizenship status.

Medicaid Expansion

The importance of Medicaid coverage for HIV prevention increased significantly with the Affordable Care Act, which permits states to extend Medicaid eligibility to all adults up to 138 percent of the federal poverty level. As of July 27, 2018, 33 states plus DC had enacted expansions[20]; on election day in November 2018, three more states (ID, NE, and UT) enacted expansions by ballot initiatives.

State Medicaid expansions have significantly increased rates of insurance coverage overall. By the end of 2016, the 31 states that had expanded Medicaid, along with DC, reported a total of 14.9 million enrollees in the adult expansion group.[21]

Studies have found dramatic increases in Medicaid enrollment in expansion states among populations relevant to PrEP. For example, lesbian, gay and bisexual people experienced an increase in Medicaid enrollment from 7 percent to 15 percent from 2013 to 2016, reflecting an increase of over 500,000 people.[22] Rates of uninsurance among young adults dropped significantly in expansion states, from 34.5 percent to 24.3 percent between 2013 and 2014.[23] Overall, the Medicaid expansion has been found to reduce income- and age-based disparities in insurance coverage; improve some insurance disparities by race and ethnicity; and positively impact access to care across most studies.[24]

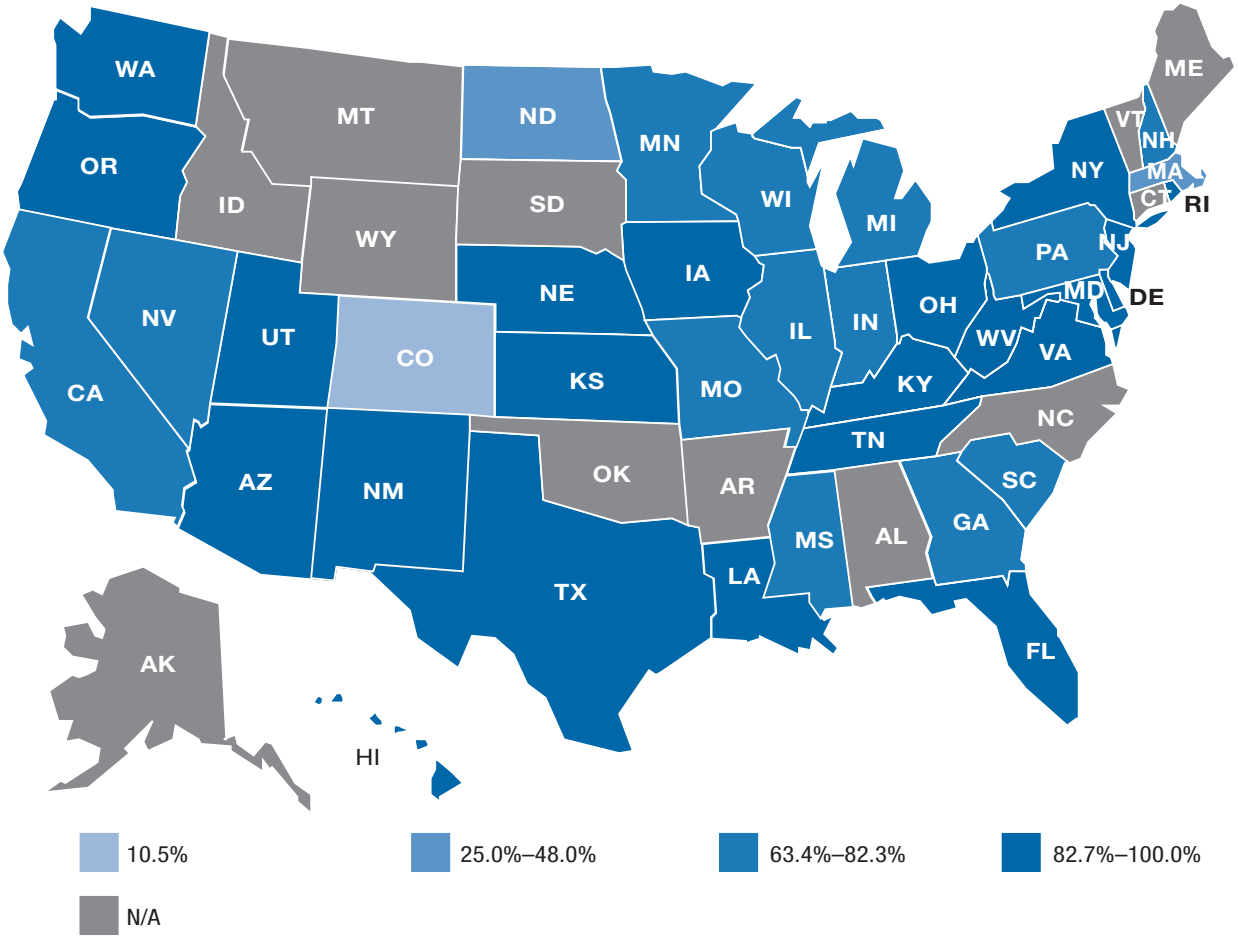
Medicaid Family Planning Eligibility Expansions

States have the option to create Medicaid family planning expansion programs that offer coverage of family planning services to people who are not otherwise eligible for Medicaid. These programs cover a narrow range of services, and it does not appear that any state currently covers Truvada itself through a family planning expansion.[25] However, the programs can be an important way to reach people with certain PrEP clinical services, including HIV and STI testing and visits, while connecting people to the manufacturer assistance program for the medication.

For example, the Open Arms Healthcare Center in Jackson, Miss., currently has approximately 200 patients on PrEP. For patients who are uninsured, a staff person submits an application to the Medicaid family planning program. For those eligible, the program covers up to four visits a year as well as labs, including STI testing and treatment, therefore reimbursing for several key components of the PrEP intervention.[26]

As of June 2017, 26 states had expanded Medicaid eligibility for family planning services under either a waiver or a permanent state Medicaid plan provision.[27] In 22 of these states, eligibility is based on income, usually set at a threshold around 200 percent FPL.[28] Nineteen states cover both men and women, with the remainder covering only women.[29]

Figure 1: From KFF, Medicaid Comprehensive MCO Penetration Rate: Total Population, as of July 1, 2017



This program may be particularly important for PrEP clinical services in states that have not expanded their overall Medicaid programs. Alabama, Florida, Georgia, Mississippi, North Carolina, Oklahoma, South Carolina, and Wyoming are non-Medicaid expansion states that did have *family planning* expansions as of 2017; all but Florida, Georgia, and Wyoming covered men.[30] In addition, even in states with Medicaid expansions, Medicaid family planning programs often cover people up to higher income thresholds, thereby reaching people who are not eligible for full Medicaid.

The scope of services covered by each state's family planning expansion program varies. As of 2009, the most recent year for which survey data was identified, 22 states' Medicaid family planning expansion programs included coverage of STI testing and labwork (though this may not extend to multisite testing or tests at the frequency recommended for PrEP); 11 also covered STI treatment.[31] Eighteen states reported covering HIV testing.[32] Some state family planning expansions also cover condoms, generally with a prescription.[33]

Fee-for-Service Medicaid

Fee for service (FFS) describes the traditional model of Medicaid, in which state Medicaid agencies pay physicians or other health care providers for each service delivered to a Medicaid beneficiary. In most states, at least some enrollees are enrolled in the FFS program (see next section for data on penetration of managed care). As discussed throughout this paper, state Medicaid agencies can have a direct role in implementing financing mechanisms to influence provider behavior through FFS payments and requirements.

Medicaid Managed Care: Landscape

In recent decades, states have significantly expanded their use of managed care approaches within the Medicaid program. Generally, Medicaid managed care refers to a range of arrangements under which states contract with entities that accept a fixed payment to provide a certain set of services to members. To inform potential approaches for bolstering PrEP intervention services, this section provides an overview of comprehensive managed care in Medicaid, and discusses managed care penetration rates – that is, the percent of Medicaid beneficiaries who are comprehensive managed care enrollees – by state.

Comprehensive MCOs

The most common model of managed care in Medicaid is comprehensive "risk-based" managed care. In this model, states contract with plans to cover all or most services to Medicaid enrollees.[34]

MCOs receive a fixed monthly payment, called a capitation payment, for each enrollee, regardless of which if any services are received that month. Some states "carve out" certain benefits from managed care, continuing to pay for those services on a FFS basis. Regardless of which services are carved out in a given state, MCO enrollees as well as enrollees in other managed care arrangements are entitled by federal regulation to all services available under the state plan, including PrEP medication and all covered PrEP clinical services.[35]

Comprehensive Medicaid Managed Care Penetration

Because Medicaid managed care poses distinct challenges and opportunities for promoting uptake of PrEP medication and clinical care, it is important for stakeholders to understand how much of their state's Medicaid population is enrolled in managed care. In 2016, approximately two thirds of all Medicaid beneficiaries were enrolled in comprehensive MCOs.[36] However, the proportion varies widely by state[37]:

Managed care enrollment also varies by eligibility category. In a national survey of state Medicaid agencies regarding enrollment in comprehensive MCOs,[38] most states reported that managed care penetration among nondisabled, nonelderly, non-pregnant adults was at least as high as that of the total population as reflected in the map above.

There is significant variation in the *number* of MCOs operating in each state with managed care, from one in North Dakota to 23 in New York.[39] To the extent different financing ideas discussed in this report would need to be broached with MCOs directly, it would be important to understand how many plans that would entail, as well as, potentially, the number of Medicaid enrollees each covers.[40]

Promoting PrEP Medication and Clinical Care through Medicaid and Medicaid Managed Care

This section explores mechanisms to support the provision of PrEP medication and clinical services within FFS Medicaid and Medicaid managed care. Given the variation in state Medicaid benefits, eligibility, and payment models, no one approach will be appropriate in every state. This section will track the financing and contractual relationships among parts of the Medicaid system to identify potential opportunities for stakeholders to consider in their respective environments.

The chart in Appendix 2 provides a visual framework for considering the key parties and "levers" to promote PrEP in Medicaid.

Role of CMS

As the federal agency administering the Medicaid program, the Centers for Medicare and Medicaid Services (CMS) could potentially play several roles in Medicaid financing of PrEP medication clinical services. CMS's Center for Medicaid and CHIP Services (CMCS) must administer the program within the bounds of federal statute but works closely with states in a variety of ways.

CMCS can send Informational Bulletins or Dear State Medicaid Director letters to all state Medicaid agencies, to inform them of news, obligations, or opportunities in the Medicaid program. In December 2016, CMCS sent a joint Informational Bulletin, along with the Department of Health and Human Services, Health Resources and Services Administration (HRSA), and the CDC, regarding "Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries."[27] The section on PrEP included specific examples of financing approaches states can take to improve access to STI screening and other clinical services:

> States have the discretion to establish certain limitations, prior authorization processes or preferred drug lists, on the coverage of PrEP to ensure appropriate utilization when medically necessary; however, we encourage states to take steps to ensure that PrEP is available consistent with USPHS recommendations. For example, neither Colorado nor Washington State subject emtricitabine/tenofovir to prior authorization processes when it is prescribed for HIV treatment or HIV PrEP. Because regular HIV and STD tests are recommended for persons who initiate PrEP, Washington's Medicaid program also facilitates access to these testing services by covering their receipt on a quarterly basis and in a range of settings that may be more convenient or comfortable for beneficiaries (e.g., family planning clinics, local health departments, or primary care settings). States should ensure that beneficiaries being initiated on PrEP are educated about and provided with sufficient supportive care to ensure adherence to regimens. Additional strategies states may consider to ensure that utilization management techniques are not designed or implemented in ways that amount to denial of access to PrEP among persons for whom it is indicated include 1) provider education, 2) development of clear policies and procedures for assessing and making determinations about indications for PrEP, and 3) careful review and monitoring of Medicaid FFS and managed care benefits and coverage.[28]

CMS could build on this informational bulletin to help guide state Medicaid agencies, and could consider whether further clarification (e.g. regarding coverage of multisite STI testing) is warranted. In addition, CMS could consider developing technical assistance for states in scaling up PrEP under Medicaid, similar to the work the agency has done to support best practices and models for addressing the opioid epidemic.[41]

State-Level Financial Policies

This section describes several key state-level financing decisions that may impact coverage of PrEP medication and clinical care within the Medicaid program: rates paid to MCOs, and how they may (or may not) reflect PrEP costs; decisions about carving components of PrEP care out of managed care; considerations for PrEP in non-comprehensive managed care models; and the potential integration of PrEP into value-based payment models in Medicaid.

Capitation Rates and Risk Adjustment: An Overview

States pay Medicaid MCOs a monthly rate for each enrollee in the plan. Under federal statute and regulations, the rate must be "projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract."[42]

Within these and further regulatory parameters, states and plans generally develop a base premium by taking into account multiple factors including baseline data, expected trends, state fiscal conditions, services that are carved out of managed care, payments in addition to the base capitation rate, and incentives.[43]

As a relatively new intervention, the cost of PrEP is likely not fully reflected in current base rates. Therefore, the impact of scaled-up PrEP use on rates could be projected by actuaries and factored into future rates. Ultimately, as PrEP uptake increases and is reflected in utilization data, the cost of the drugs and clinical services would be reflected in the capitated rate.

To reflect variation in actual plan enrollment across MCOs, states apply a risk adjustment based on factors including eligibility category, age, gender, region, and health status. With regard to health status, states vary in the risk adjustment model used, with most relying to some extent on diagnostic codes, several relying on analysis of pharmacy data, and others using a hybrid approach.[44]

Interviewees were not aware of currently available techniques to risk adjust enrollees for PrEP use. Even if PrEP risk adjustment models became available, because PrEP uptake is unlikely to be evenly distributed across plans, states will need to work with specific MCOs to develop payment approaches that meaningfully follow actual PrEP uptake. For example, one interviewee noted that states could budget for increased PrEP uptake and distribute money across plans based on projections, but conduct a "true-up" process at year's end to shift funding to where uptake actually occurred.[45]

Another interviewee pointed out that because rates are generally negotiated annually and far in advance of a plan year, there could be a lag between a state's efforts to promote PrEP uptake through MCOs, and an updated base rate and risk adjustment model that reflects that increase in services.[46] Without reflecting increased PrEP utilization in MCOs' rates in some fashion, MCOs could be reluctant to support outreach and education measures, particularly in states where pharmacy is included in the MCO contract.

Setting MCO Rates Based on Projected PrEP Services Uptake: Case Study of New York's HIV Special Needs Plans

New York State has a specialized type of comprehensive Medicaid MCO called HIV Special Needs Plans, or SNPs, specifically for people living with HIV. The plans cover the same Medicaid benefits as other MCOs in the state, along with enhanced services such as HIV care coordination case management, treatment adherence services, and risk reduction education. All primary care providers in the plan must meet state standards for HIV Specialist designation. The state developed specific capitated rates for HIV special needs plans (SNPs) based on prior utilization and cost data for people living with HIV, resulting in a per member, per month rate of approximately $5000 (compared to approximately $800 for general Medicaid managed care plans).[146] There are now three Medicaid HIV SNPs operating in the state.

As of November 2017, all transgender people may enroll in New York's HIV SNPs regardless of serostatus, a change the state made to support access to coordinated, expert services for people at high risk of HIV.[147] Amida Care, the largest HIV SNP, has supported approximately 25 percent of its HIV-negative transgender enrollees in accessing PrEP.[148] Amida is working with the state to expand SNP eligibility to all MSM, regardless of serostatus.

Rate setting for HIV-negative people enrolling in HIV SNPs was based on added costs of PrEP drugs and clinical services, incorporating a projected trended uptake model that estimated the portion of HIV-negative enrollees who would use PrEP.[149]

While HIV SNPs are a unique model, other states could look to New York for lessons in adequately setting rates for PrEP use. Specifically, the methods used to project PrEP costs, as well as trended uptake, may be useful in other settings when applied to PrEP users across non-specialized plans.

Medicaid Carveouts

One important contextual consideration for this section is whether in any state it might be advantageous to carve PrEP medication and clinical services out of MCO contracts entirely, keeping payment in the FFS realm.[47] Of the 39 states with comprehensive MCOs in 2017, the majority included pharmacy in MCO contracts; only four – Missouri, Tennessee, West Virginia, and Wisconsin – carve pharmacy entirely out of MCO contracts. California, Maryland, and Michigan generally include pharmacy in MCO contracts, but reimburse HIV drugs on a FFS basis.[48] Therefore, in those seven states, MCOs would not have financial responsibility for medica-

tion, making them less concerned about the financial impact of utilization. However, MCOs retain responsibility for PrEP clinical services.[49]

This project did not identify any states that have specifically carved PrEP clinical services out of managed care. Arguably, since doing so would remove PrEP entirely from MCOs' cost concerns, such a policy could facilitate beneficiary access, especially if Medicaid claims data or other sources indicate limited access to PrEP through MCOs. However, depending on the details, a carveout might hinder an MCO's ability to coordinate an enrollee's HIV prevention care with their other medical benefits. One potential middle path could involve initially carving out PrEP services, then reversing this policy once the costs and uptake of PrEP within a state are more clearly established and can be incorporated directly into rates.

Addressing PrEP through Non-Comprehensive Managed Care Models

As discussed above, comprehensive managed care offered through MCOs is the dominant form of managed care in Medicaid, but it is not the only model. "Medicaid managed care" can also refer to other financing mechanisms that address a more limited set of benefits or payment arrangements. States with a relevant portion of the population enrolled in limited benefit plans or in primary care case management models can also try to promote PrEP through those frameworks:

- *Limited Benefit Plans:* Limited benefit plans are arrangements in which states contract with entities to provide a subset of Medicaid services for some or all enrollees. These plans include prepaid inpatient health plans (PIHPs), which frequently focus on mental health or substance use benefits and include responsibility for inpatient behavioral health care. For example, under Michigan's Pre-Paid Inpatient Health Plan, all Medicaid enrollees receive certain behavioral health services, including substance use disorder treatment and counseling for several mental illness, from 10 organizations that receive capitated rates from the state, working with County Health Departments.[50] In states with limited benefit plans, it may be worth identifying whether any of the services related to PrEP would fall under those entities' purview, to identify the need for coordination as well as plan and provider education.[51]
- *Primary Care Case Management (PCCM):* As of 2017, 15 states had PCCM programs, in which primary care providers are paid monthly case management fees to coordinate care for assigned enrollees; the percentage of Medicaid population enrolled in PCCM in these states varied from 2 to 90 percent.[52] While the use of PCCMs has been declining and enrollment is generally lower than for comprehensive MCOs, stakeholders in states with significant PCCM enrollment may wish to explore ways to integrate PrEP into provider expectations in the program.

Additional State-Level Value-Based Payment Mechanisms

States can consider building on recent alternative ways of paying for care in Medicaid to support improved provision of PrEP care.

Many states have Patient-Centered Medical Home, or PCMH, initiatives within Medicaid. The PCMH is a model endorsed in 2007 by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA).[53] In a PCMH, a primary care physician and care team are responsible for providing or coordinating all of a patient's care across the health care system and community. In 2017, thirty states reported having at least some Medicaid beneficiaries in a Medicaid PCMH model.[54] Stakeholders can explore whether their state's existing PCMH model would support PrEP use and adherence, or if modifications could be made to increase support of PrEP.

The Affordable Care Act created additional federal funding to support Medicaid Health Homes, a model that builds on the PCMH concept for beneficiaries with chronic conditions. At the core of the financing model are six "health home" services: comprehensive care management, care coordination and health promotion, patient and family support, and referral to community and social support services.[55] All of these services could potentially support the use of PrEP for enrollees at high risk of HIV. For example, care coordination and health promotion could include coordination of enhanced HIV and STI screening and counseling; patient support could include PrEP navigation or adherence counseling; and referral to community and social support services could link PrEP users to CBOs or other entities engaged in PrEP support.

Having, or being at risk of, HIV is a potential qualifying condition for a Medicaid health home under federal law, but states have flexibility in determining whether and how to target their programs. A matrix of current state Medicaid health home models, including qualifying conditions and provider eligibility, is available.[56] A state Medicaid agency could identify whether any existing health homes in the state could be used to support PrEP, and consider initiating discussions with other PrEP stakeholders regarding modifications or developing a new model.

Another payment model growing in popularity in Medicaid is the Accountable Care Organization, or ACO. As of February 2018, twelve states have active Medicaid ACO models, and another ten or more states are pursuing them.[57] In an ACO model, providers share financial risk with regard to their patients, either through a shared-savings formula (usually evolving toward also including shared risk), or through reimbursement on a per-member, per-month basis.[58]

New York's Amida Care MCO currently has an ACO for people living with HIV but is expanding eligibility to HIV-negative people, creating an opportunity for focused efforts to support PrEP for that population.[59] While this structure may be unique, lessons learned from its development could help inform efforts to address PrEP through less targeted ACOs in other states.

Accountable Health Communities (AHCs) are shared-risk models in which the responsible entity goes further "upstream" than ACOs, and is responsible for addressing the social determinants of health in addition to clinical care and support services. Thirty-one communities are currently participating in CMS's ACH Model for Medicare and Medicaid[60]; other ACH approaches, including multi-funder models, are being supported by a range of government and foundation sources.[61] In theory, this model could provide sustainable support for programs that address structural barriers to PrEP and health in general.

Medicaid agencies can work with public health stakeholders to discuss what Medicaid ACO or ACH approaches are already in place in the state, and whether they could be adjusted or expanded to address PrEP.

Benefit Design

While some Medicaid benefit categories are mandatory, states have some discretion to design their FFS coverage packages in ways that may impact whether and how providers offer PrEP clinical services. On the managed care side, Medicaid MCO enrollees are entitled by regulation to all services the state covers.[62] However, different restrictions may apply to medication access, and MCOs can cover benefits beyond a state's basic package. This section provides an overview of how states can align benefits across a Medicaid program through MCO contract provisions. It then reviews key benefits that affect PrEP coverage, including clinical visits, medication, clinical services, labs, condoms, and targeted case management. It continues with an overview of billing and coding for PrEP medication and services, and closes with a discussion of how the USPSTF's new recommendation for PrEP could affect Medicaid benefits.

Aligning PrEP Coverage Through MCO Contracts

In some states, it may be feasible to specifically write PrEP standards into MCO contracts – addressing not only medication but also the other benefits discussed in this section. In general, there is considerable variability in the scope and granularity of the coverage requirements that Medicaid programs apply to MCOs by contract. For example, with regard to HIV broadly, a review of selected states' Medicaid MCO model contracts found that three (Florida, New York, and Texas) had detailed contract language regarding HIV clinical services; four (DC, Massachusetts, New Mexico, and Pennsylvania) had minimal specifications; and two (Georgia and Illinois) did not address HIV clinical services.[63] Understanding how prescriptive states have been in their contracts with MCOs is important context for conversations about potential contract requirements related to PrEP.

Even if a state's contracts with MCOs do not explicitly mention PrEP, a state Medicaid agency can reach out to MCOs that are not reimbursing services that the state FFS program would cover to explain why they must bring their policies into alignment. For example, in California, even though HIV is carved out of managed care contracts, claims analysis identified that in some MCOs, fewer enrollees than expected were receiving PrEP. The Medi-Cal program reached out to MCOs, both formally and informally, to discuss making their coverage of PrEP comparable to the FFS benefit. These conversations, typically with a plan's medical director, tended to result in increased PrEP uptake among the plans' enrollees as reflected in claims analyses.[64] Similarly, public health officials in Louisiana were able to educate MCOs that multisite STI test claims were neither repeat tests nor errors, but a recommended component of PrEP intervention services.[65]

State Medicaid agencies, public health agencies and providers can work together to determine approaches to aligning coverage policies across the state program to support comprehensive coverage of PrEP services. Whether to rely on general requirements that MCOs cover all state benefits, or to seek specific benefit requirements in the contract, is a state-specific question that should be discussed with each Medicaid agency.

Access to State Medicaid Contracts

Generally, states have "model" Medicaid contracts. While some may negotiate specific terms differently with different MCOs, these model contracts generally reflect overall state expectations and requirements for participating MCOs. Many states' model contracts are available online; others can be requested directly from the state Medicaid agency. Requestors should ensure that any relevant accompanying documents – such as requests for proposals (RFPs) with provisions to be incorporated in the contracts – are included.

Office Visits and Telehealth

All Medicaid programs cover office visits at various levels of complexity; the National Alliance of State & Territorial AIDS Directors (NASTAD) report described in the billing section of this report offers specific recommendations for visit types to consider using to bill for PrEP initiation, shared medical visits, and counseling.

A growing consideration for PrEP programs is access to telehealth services – clinical services offered where the patient and the practitioner are communicating in real time over a telecommunica-

tions system – to reduce patient burden for the regular screenings and visits recommended for PrEP users.[66] States have considerable flexibility to determine whether to cover telehealth services in their Medicaid programs. As of spring 2018, 49 states and DC provide for Medicaid reimbursement of some form of live video telehealth services.[67] Roughly half of states specify a specific set of facilities that can serve as "originating sites" where the patient may be; only ten states permit a patient's home to be the originating site.[68]

Telehealth coverage in Medicaid can vary by service type. Among MCOs, for example, a 2017 survey found that 37 percent of Medicaid MCOs use telemedicine for mental health or SUD counseling, along with 20 percent for chronic disease management; 32 percent did not use telemedicine.[69] In addition, some multistate Medicaid MCOs provide their enrollees with free access to national telehealth service providers, like Teladoc.[70] Telehealth providers with specific PrEP programs include Nurx and Plushcare.[71]

Stakeholders can try to work within these parameters to promote reimbursement for PrEP and PrEP clinical services, or attempt to change a state's requirements to meet the needs of PrEP patients and providers. Where MCOs are making general services like Teladoc available, the plans could work with public health and clinical partners to explore how any counseling or STI screening facilitated through the service can be coordinated with a patient's other providers as appropriate.

Medication

While states generally have considerable flexibility in Medicaid with regard to coverage of preventive services, they *must* cover Truvada under the Medicaid National Drug Rebate Agreement. Under the terms of the Agreement, manufacturers make drugs available to Medicaid plans with significant rebates, and in turn, states' formularies must include all of those manufacturers' drugs.

However, states can establish their own utilization management techniques to limit use of a drug by FFS enrollees. For example, states can maintain preferred drug lists (setting higher cost sharing for non-preferred drugs); require prior authorization based on certain clinically justified parameters; set limits on use (e.g. quantity limits on the total number of prescriptions per month); or decline to cover off-label uses.

States can choose to eliminate prior authorization on Truvada entirely. Of 16 states responding to an informal AcademyHealth survey of Medicaid Medical Directors, 12 reported having no prior authorization or other utilization management requirements on Truvada for PrEP within their FFS programs.[72]

A brief prior authorization requirement, for example requiring a physician to confirm that the patient is HIV-negative, may be both medically reasonable and not unduly burdensome.[73] However, to the extent a state applies restrictions that increase provider burden (e.g. lengthy prior authorization requirements), provider participation in PrEP – and therefore in PrEP clinical services, could be limited.

State Medicaid agencies should assess any FFS prior authorization requirements for Truvada as PrEP to assess whether they serve as useful clinical tools or unnecessary barriers to care. They could work with providers in the state as well as public health officials to identify an appropriate PA policy for the state FFS program.

In most states, MCOs can place different controls on utilization of covered medications. For example, one interviewee reported that some MCOs in New York State have reportedly applied prior authorization requirements for PrEP that operate as a "speed bump" to access.[74]

Some states apply standardized or "common" Medicaid formularies, requiring MCOs to use the same set of utilization management approaches, either to all pharmacy or to a particular drug or drug class.[75] State Medicaid programs could consider whether to apply this approach for PrEP medication to create consistent access.

STI Testing and Treatment

Medicaid FFS programs typically cover some STI testing as well as the other clinical components of the PrEP intervention, such as HIV screening, pregnancy testing for women, and other lab tests.

However, programs may not formally cover testing on a quarterly basis and may not always cover the multisite STI testing required for some PrEP users. For example, the CDC recommends that for MSM receiving PrEP, quarterly gonorrhea and chlamydia nucleic acid amplification test (NAAT) be conducted on pharyngeal, rectal, and urine specimens ("3-site testing"). The CDC recommends NAAT testing of vaginal specimens for women who engage in vaginal but not anal sex, and of both vaginal and rectal specimens for gonorrhea and chlamydia among women who report engaging in anal sex.[76] Medicaid payment systems may reject multiple claims for tests for the same disease for the same person on the same day, either because of a specific payment policy, or because systems are simply not designed to accept multiple lab claims for one disease in a given day.

In AcademyHealth's informal survey of the Medicaid Medical Director Network regarding PrEP coverage, respondents were asked if their state FFS program would "pose any barriers to coverage of quarterly, multi-site STD testing." Of 15 states with FFS programs

responding, seven stated that the program would not pose barriers; one stated that the program wouldn't pay for a second test on the same day; and seven were indeterminate, with answers including "depends," "I do not believe so," and "probably." These responses suggest that state Medicaid agencies could start by clarifying whether their own policies and systems support multisite, quarterly testing without barriers.

MCO practice also varies with regard to STI claims. For example, Dr. Divya Ahuja of University of South Carolina indicated that among his PrEP patients, he perceives a smoother process for approval of multisite screening for FFS enrollees; MCOs seem to more frequently require one or more calls from a physician or other staffer before approval is granted (though his office had not formally evaluated this pattern).[77] An MCO interviewee suggested that rejections of multisite STI testing claims are more likely to reflect logistical issues like automatic payment systems, rather than specific policies against covering multisite testing.

Challenges associated with claims for multi-site STI testing are not specific to Medicaid. One provider in a non-Medicaid expansion state reported frequent rejections or pushback for multisite STI claims for *privately*-insured patients, as well as significant variation in how private plans manage PrEP-related codes, resulting in a lowered likelihood of additional revenue for billing all components of PrEP.[78] This suggests that multi-payer approaches or alternative payment models could create a more consistent billing and reimbursement environment for PrEP providers.

Lab Validation

Not all labs have undergone validation to support extra-genital (pharyngeal or rectal) site testing, posing a barrier to the multisite testing recommended for most PrEP users.[150] This problem is not unique to Medicaid but must be addressed to allow Medicaid reimbursement. Public health departments and Medicaid agencies could work to ensure that all labs receiving Medicaid reimbursement in the state can conduct validated testing on all types of specimens, or alternatively that enough Medicaid-participating labs are available to meet demand.

State Medicaid agencies and their MCOs can assess their lab reimbursement protocols for STIs to identify and address any barriers to reimbursement of PrEP-associated labs. If needed, the state Medicaid agency and MCOs could work with public health experts to align coverage policies with CDC guidelines. For example, public health officials in Louisiana became aware that the state Medicaid program was rejecting lab claims for multi-site STI tests, only allowing one claim to go through. They were able to work with the office to achieve reimbursement for two sites; the public health staff will be revisiting the issue to confirm if three-site reimbursement is now occurring.[79]

Challenges regarding Medicaid coverage of other tests recommended as part of PrEP, including HIV and hepatitis B tests, as well as renal function tests, have not been identified in the literature or interviews, but could similarly be discussed with state Medicaid agencies and MCOs if problems arise.

Condoms

The CDC's PrEP guidelines note that "[t]he importance of using condoms during sex, especially for patients who decide to stop taking their medications, should be reinforced."[80] In many states, Medicaid can reduce financial barriers to condom use. As of July 2015, 27 states of 41 responding to a survey reported covering condoms in their traditional (non-expansion population) Medicaid programs; 18 reported covering condoms for their expansion populations and 18 under their Medicaid family planning expansions waivers or amendments.[81] The majority of states covering condoms require prescriptions for reimbursement.

Because condoms require a prescription to be covered, Medicaid and public health stakeholders should ensure that providers are aware of the appropriate procedures to prescribe condoms for PrEP users to trigger Medicaid reimbursement.

Case Management, Care Coordination, and Peer Support

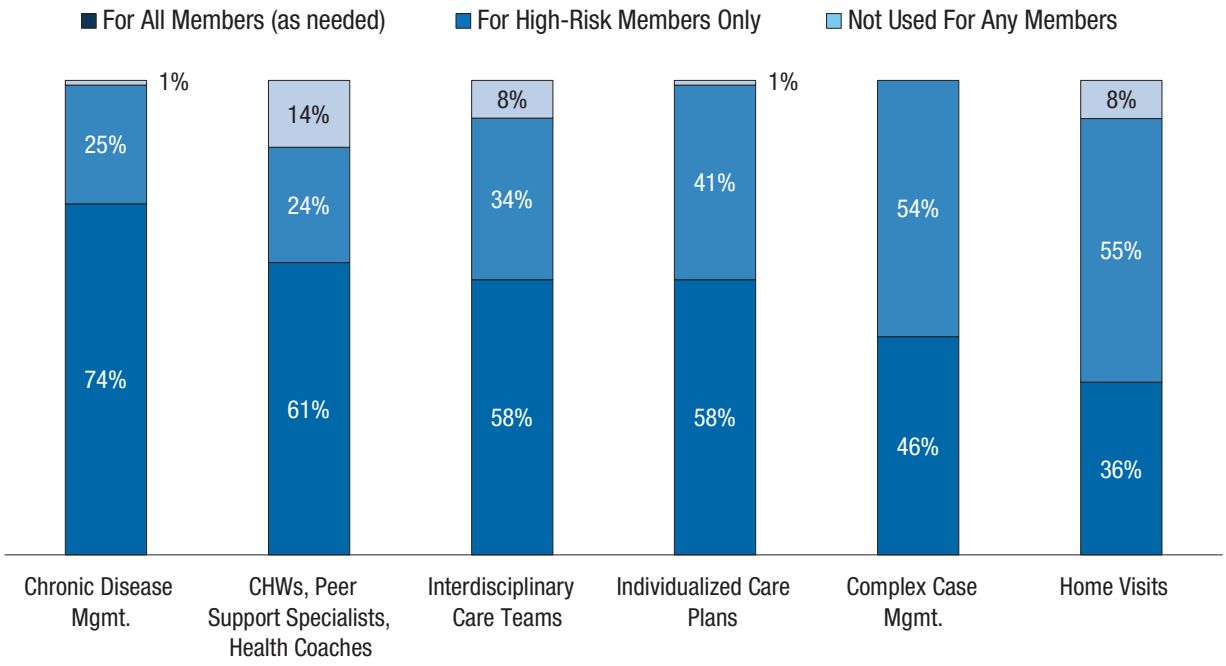
Services to help coordinate and support care for PrEP users could be implemented as a state benefit or as an "additional" service covered by an MCO.

Targeted Case Management

Targeted Case Management (TCM), an optional Medicaid benefit, allows states to cover enhanced case management services to help certain categories of beneficiaries (or beneficiaries in certain parts of a state) access medical and other services. Because TCM can be developed for specific populations – e.g. adolescents, men who have sex with men – it could be developed in a way that addresses specific barriers to PrEP use and adherence to PrEP medication and clinical services. A number of states' Medicaid programs include targeted case management for people living with HIV. Rhode Island has expanded this concept to make TCM available for certain beneficiaries at high risk of HIV,[82] creating a reimbursement mechanism for services around linking people to PrEP and encouraging their adherence to PrEP clinical services.[83]

Medicaid agencies, public health agencies and PrEP providers could explore whether their states have existing TCM benefits that could be modified to support beneficiaries who are candidates for PrEP and other services, or whether such a benefit can or should be developed.

Figure 2: Share of Medicaid MCOs Using Strategies to Promote Coordinated Care



NOTES: "Don't Know" responses not shown. CHW = Community Health Worker.
SOURCE : Kaiser Family Foundation Survey of Medicaid Managed Care Plans, 2017.

Peer Support and CHWs

Medicaid regulations permit states to reimburse non-licensed providers for providing preventive services, as long as the services are "recommended by" a licensed provider. This provision would permit states to reimburse community health workers, peer navigators, or similar support workers engaged in the provision of PrEP. To make this change, states would need to submit a state plan amendment to CMS detailing the types of services and providers they propose to reimburse. While uptake of this provision for any kind of preventive service has been limited, Medicaid agency and public health officials could explore whether an amendment to cover non-licensed support providers who offer PrEP would be feasible. If a state implements this option, community health workers (CHWs) could potentially bill for PrEP support services under "Self management education and training"; in some states, CHWs could potentially also be reimbursed for Targeted Case Management (see prior section).[84] States could develop specific protocols indicating the amount, scope, and duration of PrEP case management services to be covered.[85]

State Medicaid agencies could work with other stakeholders to identify existing policies regarding reimbursement of peer support services, and discuss potential reimbursement of PrEP peer supports, navigators, or case managers.

Other MCO Care Coordination Strategies

MCOs can provide care coordination services beyond what's included in a state plan or waivers, at times motivated simply by the identification of a need among their enrollees.[86] This may include types of care coordination applicable to PrEP. Currently, as shown in Figure 2, most Medicaid MCOs report using a range of strategies to promote coordinated care[87]:

MCOs could work with other PrEP stakeholders to determine whether and how care coordination for PrEP could be integrated into existing or emerging strategies, for example by including PrEP users as eligible for care coordination services. Partners for such coordination services could include local health departments or CBOs, or those entities could provide training on PrEP to current care coordination providers. MCOs could also consider directly paying for additional staffing at provider facilities with high numbers of enrollees who are PrEP users to conduct care coordination.

To the extent a Medicaid MCO pays for services that go beyond the state's Medicaid benefit package, the MCO must use administrative rather than medical services funds. Regardless, MCOs may be motivated to provide these services to improve their enrollees' health. In addition, quality improvement activities such as care coordination for PrEP, can count toward the numerator of a plan's "medical loss ratio" or MLR. The MLR reflects the proportion of total capitated payments received that are spent on clinical claims and quality improvement. Medicaid MCOs must meet a minimum 85 percent MLR, with most states requiring plans to remit funds to the state if the ratio is not met. Therefore, the inclusion of quality improvement in MLR offers plans an incentive to invest in the kinds of coordination and navigation activities that could support PrEP clinical services.

Table 3: Potential Practice Quality Measures from CDC PrEP Clinical Providers' Supplement, 2017

Quality Indicator	Eligible Population	Numerator	Denominator
HIV testing, baseline medication	All persons prescribed PrEP medication	Number of patients with negative HIV test result documented within 1 week prior to initial prescription of PrEP	Number of persons prescribed PrEP
HIV testing, interval	All persons prescribed PrEP medications	Number of PrEP patients with an HIV test result documented at least every 3 months while PrEP medication prescribed	Number of persons prescribed PrEP for >3 months continuously
PrEP medication adherence	All persons prescribed PrEP medications	Number of PrEP patients with adherence assessment noted in the medical record for any visits when prescribed PrEP medication	Number of persons prescribed PrEP medication
Seroconversion	All persons prescribed PrEP medications	Number of patients with a confirmed HIV positive test result while PrEP medications prescribed	Number of persons prescribed PrEP medication for >1 month
Seroconversion, resistant virus	All persons prescribed PrEP medication who received a genotypic resistance test within 4 weeks after an HIV positive test result	Number of persons seroconverting while taking PrEP who have resistant virus detected by genotypic test	Number of persons prescribed PrEP medication who received a genotypic resistance test within 4 weeks after a confirmed HIV positive test result

Coding and Billing for PrEP

NASTAD has prepared a detailed guide for providers seeking to bill Medicaid and other payers for PrEP clinical services.[88] The guide details procedure codes and diagnosis codes for billing key elements of the intervention, including:

- A medical office visit for PrEP initiation;
- Shared medical visits (multiple providers, including at least one physician, APRN, or PA);
- Preventive medicine counseling and/or risk factor reduction intervention, individual or group;
- Labs for PrEP initiation and ongoing monitoring;
- PrEP adherence counseling; and
- High intensity behavioral counseling to prevent STIs.

As discussed in the guide, state Medicaid programs differ in their requirements as to who can provide each service. For example, some permit certain services to be provided by a non-licensed staff number "under the supervision of" a physician, APRN, or PA.

The U.S. Preventive Services Task Force and PrEP

In November 2018, the USPSTF issued a draft "Grade A" recommendation for PrEP for HIV.[89] If finalized, this recommendation would trigger statutory coverage requirements that the recommended service be covered without cost-sharing by nearly all private issuers, as well as for Medicaid expansion enrollees. In addition, such a recommendation could enhance overall provider engagement efforts with regard to PrEP. It remains to be seen whether the USPSTF recommendation, if finalized, will explicitly include HIV and STI testing and the other PrEP clinical services in a way that translates into clear coverage requirements for those clinical services.

Performance Improvement

In the Medicaid program, the quality of care covered by MCOs and delivered by providers can be addressed through performance incentives at various levels. This section discusses incentives for improving PrEP care at the plan level, incentives that states can offer providers directly by the state FFS program, and approaches that MCOs apply to reward performance for providers in their networks.

At any level, using performance measures to improve PrEP care requires valid measures. The CDC's 2017 PrEP guidelines include five "Potential Practice Quality Measures" (see Table 3).[90] While none have been tested and validated according to commonly endorsed standards, eventually they – or other nationally developed or state-specific measures – could be used to evaluate the performance of providers and MCOs in offering PrEP medication and clinical services. As an interviewee noted, any discussion of metrics for PrEP clinical services must take place in a broader discussion about PrEP metrics overall, and perhaps incorporate risk adjustments to reflect populations that may be more difficult to reach and retain with consistent PrEP services.[91]

Incentives for Plan-Level Quality Improvement

State Medicaid agencies could build specific incentives into their contracts with MCOs to stimulate the provision of recommended services.[92] In FY17, the majority of managed care states reported using one or more quality improvement approaches for MCOs: 22 used "pay for performance" bonuses for reaching certain performance thresholds; 29 used "capitation withholds" or penalties for plans *not* meeting performance thresholds; and 36 required data collection and reporting for quality improvement.[93] More states were planning new or expanded quality improvement initiatives. For example, Michigan's "Bonus Template" for Medicaid MCOs involves a total funding withhold; plans can recover 'bonus dollars' for meeting state-set performance goals in areas of population health, health equity, access to care, and community collaboration.[94] Tennessee's pay for performance program gives MCOs an additional per member, per month payment when they meet HEDIS performance thresholds, with measures selected by each MCO from among a set of state-identified options.[95] While no PrEP-specific performance-based contract provisions were identified in research or interviews, they could be developed and applied.

In addition to financial incentives to MCOs, states can reward high-performing plans with priority for auto-assignment of enrollees who do not select a plan themselves.[96] A PrEP measure could be integrated into auto-assignment preferences as well.

States can also require Medicaid MCOs to engage in specific targeted Performance Improvement Projects, or PIPs. A PIP around PrEP coverage and engagement could give MCOs an opportunity, on their own and collaboratively, to closely examine the quality of care and coverage they are providing PrEP users and identify necessary changes.

Medicaid agencies could work with public health officials to identify whether existing MCO quality improvement initiatives could integrate PrEP care. Often, plans are assessed based on HEDIS performance measures, a standard set of plan quality metrics, which do not currently include any PrEP measures. States are not bound by HEDIS or NCQA-approved measures[97]; they could develop their own metrics around PrEP, and pilot models based on them.[98] However, plans (and providers) may be more likely to resist relatively novel metrics, particularly if linked to penalties or incentives. In addition, states would need to be persuaded that PrEP is a significant enough issue to merit the intensive and complex negotiations around performance measures in MCO contracts.

State Medicaid Agency Direct Financial Incentives to Providers

In states with significant fee-for-service enrollment, state Medicaid agencies could undertake a range of financing policies to directly influence provider behavior regarding PrEP.

One approach is to offer incentives for providers who meet certain standards. Linking incentives to performance would require reliable performance measures linked to PrEP medication and clinical services.

Notably, performance measures could face opposition from providers, who are working with many performance measures and incentive systems across a broad range of health issues. In addition, the relatively small number of PrEP users in any given provider's panel could render performance data unreliable.

While clinic-based quality measures for PrEP services may be a goal, an initial interim step in some contexts could be linking financial incentives to more easily measured provider behavior such as participation in training or academic detailing on PrEP, or in trainings on bias and patient engagement related to PrEP and other sexual health services.

Medicaid agencies and public health officials could identify any existing provider incentive initiatives in their states' FFS programs and determine if PrEP medication and clinical services could be integrated into the model.

MCO Provider Payment Models

Most MCOs pay at least some providers on a fee-for-service basis. However, in nearly all states, MCOs are also using various alternative payment models.[99] In FY17, 93 percent of plans surveyed reporting using "pay for performance" for providers, 38 percent reported using bundled payments and 44 percent reported using other shared-savings or shared risk arrangements.[100]

Pay for Performance

Like state FFS programs, MCOs can create incentives linking provider payments to meeting certain standards of performance. As discussed above, this approach for PrEP, as well as for PrEP clinical services, would depend on the development of performance measures acceptable to both plans and providers. The feasibility would also depend on whether the relevant performance information could be gleaned from claims data, or whether it would require information from medical records or other sources. Offering payment incentives for appropriate provision of PrEP clinical services could be tailored to specific specialties (e.g. infectious disease, internal medicine, or family practice) within an MCO's network.

Bundled Payments

The term "bundled payments" does not have a single meaning in payment policy – rather, it can be used in different contexts to describe a broad range of payment types, including:

- A single payment for a particular type of office visit;
- An "episode-based" payment, such as paying a health system for a patient's knee surgery and all related services prior and in followup to it; and
- "Global" payments (e.g. per member, per month (PM/PM) to a group or system in return for providing a certain type of care). This is sometimes referred to as "subcapitation."

One PrEP provider interviewed stated that a per-visit bundled rate from Medicaid MCOs for PrEP would be ideal, but anticipated that in most cases providers will have to continue to get as much as possible out a standardly-reimbursed visit.[101] It is also important to note that in much of the literature, the "success" of bundled payments is discussed in terms of financial savings, though measures are typically put in place to maintain quality.[102] PrEP stakeholders should therefore consider both the feasibility and value of pursuing bundled MCO payments to providers for PrEP.

Shared Savings or Shared-Risk Models

Shared savings models are structured in a way that allows providers to benefit if the quality of patient services yields savings; shared-risk models can also include providers' accepting "downside" risk if costs are higher than anticipated. Overall, many practices may not be ready to engage in risk-sharing, particularly down-side risk, for PrEP or for care provision in general. In addition, PrEP may not generate enough costs, or savings, to rise to the level of warranting a shared savings model.

Access to PrEP Providers

Patients can only access PrEP medication and clinical care if they have access to care providers.

States with significant FFS enrollment should work with public health stakeholders and providers to ensure that PrEP providers are participating in the program and accepting new Medicaid patients. If not, they should work to identify barriers and potential solutions.

Comprehensive Medicaid MCOs contract with a specific network of providers – including clinicians, health care facilities, and laboratories – to provide care to their enrollees. Generally, a provider must be part of a specific MCO's network to receive reimbursement for services provided to that MCO's enrollees.

Current federal law and regulations require states that use managed care to develop "network adequacy" standards for certain provider categories, which are not PrEP- or HIV-specific.[103] However, states can choose to develop further standards; in theory, a state Medicaid agency could by contract require MCOs in the state to include PrEP providers in their network.

MCOs can also go further to ensure that their networks meet the needs of their enrollees. In addition to considering statewide PrEP network adequacy standards, MCOs could work with public health stakeholders to evaluate their networks and identify PrEP providers to meet their members' HIV prevention needs.

Lessons from MCO Support of Medication-Assisted Treatment for Opioid Addiction

A recent report for the Association for Community Health Plans detailed the strategies that several Medicaid MCOs are using to support and engage primary care physicians in prescribing Medication-Assisted Treatment (MAT) for opioid use disorder.[151] Like PrEP, MAT is an evidence-based tool that has been underutilized within Medicaid programs and more generally. However, MAT has taken on increased urgency because of the national opioid epidemic, and the ways MCOs have approached its scaleup could help inform PrEP efforts.

The authors of the report identified provider barriers that in several ways echo those involved with PrEP: a lack of provider education; the additional management burden of MAT practice; and stigma related to the patient population and to the underlying risk behavior.[152]

MCOs profiled in the report used a variety of approaches to engage new MAT providers and to support and maintain existing providers. Examples of strategies that used financial incentives include the following:

- UPMC (Pa.) offers performance-based payments for providers who meet multiple MAT-related quality indicators. The payments can be used to hire social workers or nurse care managers, or to otherwise strengthen treatment services.
- Inland Empire Health Plan (Calif.) will be including payment for out of office MAT training time in its provider contracts.
- Partnership Health Plan (Calif.) gives financial incentives to primary care providers who are willing to take MAT referrals and conduct specific monitoring activities.
- Geisinger Health Plan (Pa.) provides bundled payment for MAT prescribers to reduce provider administrative burden. The payment is a per member, per month amount that includes an initial visit; initiation of MAT, stabilization, and maintenance (drugs are reimbursed separately). Providers send a weekly list of MAT patients to the plan; the model does not currently include quality requirements, but Geisinger is considering their inclusion.[153]

The existing website https://preplocator.org is a searchable directory of clinics and providers who offer PrEP. It is not exhaustive – relying on direct submissions or confirmations from providers – but could inform first steps in determining an MCO's network adequacy with regard to PrEP. Such efforts could be paired with ensuring that MCO networks includes STI clinics, other public health clinics, and infectious disease doctors, thereby reaching a slate of providers who may be more likely to offer PrEP services.

Partnerships with Local Health Departments and Community-Based Organizations

Local health departments (LHDs) or CBOs could, in some cases, serve as quality providers of PrEP clinical services or support services. Public health stakeholders could, through a formal "certification" or informally, help identify public or community-based entities in the region that are qualified to support PrEP users and providers.

This section describes how state Medicaid agencies could support LHD and CBO engagement in PrEP directly or by encouraging or requiring MCO engagement, as well as how MCOs could support LHD and CBO engagement.

State Medicaid Agencies Directly Supporting Local Health Departments or CBOs

State Medicaid agencies could reimburse local health department STD or primary care clinics or community-based providers that offer PrEP and/or PrEP clinical services for Medicaid enrollees.

Health-department-run clinics, including STD clinics, are important sites for initiating PrEP medication and clinical services or, for some clinics, maintaining patients on PrEP. Health department clinics that do not currently have or intend to have the capacity to initiate or deliver PrEP also serve a crucial role in actively referring patients to providers in the community.

A 2015 survey from NACCHO (National Association of County and City Health Officials) of local health departments (LHDs) that provide or contract out HIV or STI screenings found that almost one third were engaged in some way in PrEP. Those that directly provided services or ran STD clinics were more likely to be engaged in PrEP.[104] "Engagement" varied, with 74 percent making referrals to PrEP providers, and only 9 percent delivering PrEP, though almost a third of LHDs who were at all engaged with PrEP saw direct provision as an "optimal" role for LHDs.[105] While these figures may have increased in the intervening years, one interviewee reported that an increasing number of LHDs see their role as initiating patients on PrEP and working to transition them to other primary care providers, if that is an option.[106]

When LHDs do engage in providing PrEP medication, clinical care, and support services, Medicaid might not always be billed. The NACCHO survey found that only 47 percent of respondent LHDs – all of which were directly providing STI or HIV services – reported billing Medicaid at all.[107] In some states, public STD clinics are legally prohibited from billing insurance, including Medicaid.[108] When asked if their state Medicaid program pays for PrEP, 75 percent of respondents in the NACCHO survey selected "Don't know."[109]

These data are consistent with a concern expressed by a member of the steering committee that public clinics may be serving PrEP patients without receiving reimbursement, even when those patients have Medicaid coverage.[110] This could be due to a range of factors, including confidentiality concerns (particularly for adolescents or young adolescents who share an address with their parents), or visits being conducted by nonbillable providers (e.g. RNs). In addition to being a non-optimal use of health department funds, this potential pattern could make it difficult to identify problems when billing Medicaid for STI services because Medicaid is not, in fact, being billed (for PrEP or for any services). A further concern is a potential lack of coordination/communication between providers offering different components of the PrEP service suite.

Stakeholders could explore whether Medicaid reimbursement for LHD provision of PrEP and related clinical care is being maximized within the parameters of their state's laws and payment policies. Within this assessment, stakeholders could also determine if eligible public primary care or STD clinics in the state are in fact participating in the 340B program, which requires Medicaid-participating pharmaceutical manufacturers to offer deep discounts on drugs to certain categories of registered safety net providers, including STD clinics.[111]

For non-clinical CBOs, State Medicaid agencies could develop contracts or agreements to offer PrEP support services. Because support of non-clinical CBOs is not a traditional role for Medicaid in all states, public health agencies can help identify opportunities for this engagement.

MCO Collaboration with LHDs or CBOs

On the managed care side, MCOs could also establish contracts or memoranda of understanding (MOUs) with local health departments to offer PrEP medication and/or clinical services to enrollees. MCOs may undertake such actions based on their members' needs; stakeholders could also explore whether current state MCO contract language could encourage or require MCOs to engage with LHDs and CBOs, for PrEP or more broadly.

In addition to reimbursing LHDs for clinical care, MCOs also have the flexibility to consider more novel ways of incorporating LHD services into PrEP care. For example, Medicaid MCOs could help support Disease Intervention Specialists (DIS), funding them in a way comparable to CHWs, to serve the STI tracking and care coordination needs of their enrollees. This approach would extend beyond PrEP, and involve engaging MCOs in understanding the benefits of LHD and DIS involvement with STIs for their communities' health and their financial bottom line.

MCOs could also work with non-clinical CBOs to support PrEP users. For example, in a model that could be considered for PrEP support, AIDS Foundation of Chicago (AFC) contracts with two Medicaid MCOs. Under the "Reach and Engage" service package, AFC conducts outreach to members deemed "unable to locate" to connect and re-engage them with primary care providers.[112] One MCO pays a flat monthly rate; another pays on a PM/PM basis. Members assigned to AFC include some who are HIV-positive as well as others who are at high risk of HIV. This type of model could be useful in the PrEP arena; for example, a non-clinical CBO could propose to work with MCOs to support various parts of PrEP, such as linking PrEP users to a range of clinical services.

AIDS United has developed a set of webinars and resources to support CBOs in approaching MCOs.[113] The Association for Community Affiliated Plans also has multiple resources, including a factsheet highlighting of range of examples of Medicaid MCO partnerships with local organizations.[114]

MCOs can similarly engage with community health workers, on their own initiative or under a state contractual requirement. For example, Michigan's Medicaid MCOs are required by contract to support CHWs.[115] Priority Health, a Medicaid MCO and integrated delivery system, employs CHWs and additionally contracts with a vendor to directly address enrollee needs in a specific portion of the state.[116] CHWs both within and outside the plan help identify and address enrollees' social determinants of health.[117] Medicaid agencies and MCOs could work with public health agencies to explore supporting qualified CHWs as PrEP navigators.

Specific Considerations Linked to Provider Type and Setting

PrEP scaleup may in many contexts rely on the engagement of providers other than physicians, and settings other than a traditional clinical setting. This section reviews certain considerations related to Medicaid reimbursement for non-physician providers, as well as issues related to pharmacy reimbursement, federally-qualified health centers and rural health centers.

Nurse Practitioners and Physician Assistants

Within a given state, engagement of nurse practitioners (NPs) and physician assistants (PAs) in PrEP would depend on both scope of practice and reimbursement. Scope of practice issues are not specific to Medicaid, but Medicaid and public health stakeholders need to understand the opportunities and limitations for these providers at the state level. In 26 states, NPs have prescribing authority only within the bounds of a relationship with a physician; in 11 states NPs must complete a transition period toward full prescribing authority; and in 13 states plus DC, NPs have full prescribing authority (see www.scopeofpracticepolicy.org for details by state).[118] For PAs, who generally work with a supervising physician, in most states prescriptive authority is determined by agreement between the PA and that physician.[119]

Nurse practitioner (NP) visits can be billed to Medicaid[120] as long as services provided are within the state's scope of practice laws. State FFS programs generally reimburse NPs at between 75 and 100 percent of the physician reimbursement rate.[121] A NP interviewed stated that she generally bills her PrEP visits as a Level 3 established office visit, which allows for counseling and risk reduction.[122]

All Medicaid programs offer reimbursement for services provided by Physician Assistants operating within their scope of practice, but in some states reimbursement may be through the supervising physician. The rate may be lower than that paid for services provided by physicians or the same, depending on the state.[123]

Services Provided by Registered Nurses

As noted by one infectious disease doctor interviewed for this project, one way to reduce the burden of repeated STI testing on prescribers would be to task-shift the testing to RNs.[124] Jason Farley, a PrEP provider and researcher and the immediate-past President of the Association of Nurses in AIDS Care, maintains that non-prescribing RNs could in fact run a PrEP clinic under standing orders, with the nurse conducting clinical monitoring and the patient self-swabbing for STIs.[125] In this model, a prescribing provider could be consulted for specific cases such as seroconversion, nonadherence, or a diagnosed STI in need of treatment. Lyn Stevens of New York State's Department of Health echoed the belief that some ongoing PrEP services and visits could be conducted by RNs.[126]

However, multiple interviewees noted that visits with *only* a registered nurse are not reimbursable in their specific settings.[127] Reimbursement of RN visits should be assessed at the state level to determine what PrEP clinical services can be supported under this model.

Pharmacies and Pharmacists

Pharmacies and pharmacists can play key roles not only in dispensing PrEP medication but also in supporting adherence to PrEP and to PrEP clinical services through various models.

In pharmacies with clinics that employ health care providers with prescribing authority, providing PrEP is relatively straightforward. For example, at certain Walgreens sites, health care clinic providers are able to prescribe PrEP, along with conducting STI and HIV screenings.[128]

Pharmacists may also be able to provide most or all PrEP services directly, depending on the practice arrangements permitted under state law. For example, in Seattle, the Kelley-Ross Pharmacy runs a "One-Step PrEP" clinic under a collaborative drug therapy agreement.[129] Pharmacists conduct initial meetings, sexual histories, lab testing, and education, in addition to dispensing medication.[130] An estimated 20 percent of the clinic's PrEP patients are Medicaid enrollees, most enrolled in MCOs. The pharmacists can bill visits on the same terms as other providers based on level of service, and can conduct all necessary lab testing with Medicaid reimbursement.[131]

In Iowa, collaborative practice agreements between MDs and PharmDs allow the pharmacists to provide expanded PrEP services.[132] Providers conduct an initial PrEP visit through either telehealth or an LGBTQ+ clinic, and pharmacists do monitoring and follow-up visits.[133]

For pharmacies acting within more traditional bounds of practice, Medicaid reimburses for drugs and pays pharmacists a small dispensing fee. However, in some states, Medicaid will reimburse pharmacists for enhanced medication therapy management, or MTM services.[134] In theory, MTM eligibility could be extended to persons on PrEP and include enhanced counseling and reminders about renewals.

Stakeholders could explore their states' pharmacist practice agreements and Medicaid financing models for pharmacies, including whether their state Medicaid program has an MTM model that could be applied to pharmacist engagement in PrEP.

Federally-Qualified Health Centers and Rural Health Centers

As community-based providers of comprehensive and coordinated primary care services,[135] federally-qualified health centers (FQHCs) should be an important locus for the provision of PrEP medication and clinical services. FQHCs receive federal funding from the Bureau of Primary Health Care within HRSA to offer care; they serve both uninsured and insured patients, including Medicaid enrollees. FQHCs' unique Medicaid reimbursement structure creates both opportunities and challenges for provision of PrEP medication and clinical services.

Under federal law, state Medicaid programs pay FQHCs under a prospective payment system (PPS), using a set, per-visit rate based either on cost reporting or on local averages.[136] This per-visit rate includes all services provided during a visit with a licensed provider, encompassing not only the primary encounter but, for example, any nurse or lab services provided in the visit. Some states have "unbundled" certain services from the PPS rate in order to incentivize their provision; for example, some states reimburse FQHCs the actual acquisition costs for long-acting reversible contraceptives, on top of the PPS rate.[137]

Medicaid MCOs are not required under federal law to pay FQHCs the PPS rate, but must pay at least what they would pay a non-FQHC provider for the same services. However, FQHCs must *receive*, in the aggregate, at least the amount they would have earned under the PPS payment. Therefore, states must make "wrap-around" payments to FQHCs if the MCO reimbursement is in fact lower, in the aggregate, than the PPS.

Under federal law, similar Medicaid payment provisions apply to Rural Health Centers, which are certain facilities in "nonurbanized," underserved areas.[138]

Whitman-Walker Health, an FQHC in Washington DC, provides PrEP intervention services to approximately 2,000 people, an estimated 30-35 percent of whom are Medicaid enrollees.[139] As an FQHC, Whitman-Walker serves many vulnerable patients, requiring wraparound care to meet patients' health needs. Therefore, the cost reporting on which the clinic's PPS rate is based includes not only clinical services but also support services, including such as care navigator and retention manager. The resulting enhanced rate, higher than the typical commercial reimbursement Whitman-Walker receives for the clinical services only, still falls short of covering all PrEP-related services the clinic offers. Importantly, FQHC reimbursement rates can vary by state and by facility.[140] Because PPS rates are only negotiated every few years, they are often not reflective of current year expenses, and may not reflect the costs of emerging technologies or newer services like PrEP.

Whitman-Walker has been able to establish a specific PrEP clinic which to date has seen approximately 200 of their PrEP patients. The patients see both a nurse and phlebotomist in a brief visit to streamline their receipt of PrEP clinical services. These patients do not otherwise come to the center frequently for other medical care (though the patients do see a clinical provider at least once per year, for annual wellness visits, per 340B program requirements). Other

than the lab work, the visits are not reimbursable by Medicaid or other insurance because the patients do not see a Medicaid-reimbursable clinical provider in this visit. However, Whitman-Walker reports that it is worth it to use clinic funds to support this immediate PrEP access option so that this subset of patients receive PrEP adherence support and STI testing on demand.[141]

FQHCs, like STD clinics, are eligible for the 340B drug pricing program. An FQHC with its own pharmacy, or that contracts with pharmacies in the community under 340B, can buy drugs at the 340B discounted rate.

Stakeholders can work to promote provision of PrEP medication and clinical services at FQHCs, at the local, state, and federal levels. Locally, public health agencies can determine if FQHCs are providing PrEP and work to identify barriers, including those related to Medicaid reimbursement. At the state level, the Medicaid agency can work with public health stakeholders to analyze FQHC reimbursement and whether modifications can be made to adequately support PrEP medication and clinical services. Federally, HRSA can work with CMS and the CDC to identify opportunities, such as developing ongoing training opportunities or clinical practice resources for FQHC staff. While these queries and approaches focus on the Medicaid lens, they could serve to identify broader barriers and opportunities to PrEP at FQHCs.

Further Considerations for Medicaid Benefits and Financing

A number of additional opportunities and challenges should be considered at the state level to help optimize Medicaid support of PrEP intervention services.

Leveraging Medicaid Data to Increase Access

Multiple interviewees agreed that Medicaid claim data should be leveraged to improve provision of PrEP clinical services to current PrEP users, as well as to increase PrEP uptake and adherence. Because Medicaid agencies do not always have staffing or resources to spare for new analyses,[142] public health stakeholders may need to develop or expand existing data sharing agreements with state Medicaid agencies, or work together to identify a third party that could conduct the analyses. [143]

For benefit design and financing purposes, Medicaid claims data could potentially be used in at least three ways:

- Identifying the current rate of PrEP use in the Medicaid program, including stratification by certain populations, to help optimize how the benefit is structured and financed;
- Tracking the provision of clinical services to current PrEP users, in part to inform calculations of value, potentially for value-based payment approaches; and
- Identifying candidates for PrEP, based on STI-related claims or other indicators from Medicaid data, to consider the potential impact of broad, population-based models for improving PrEP coverage and uptake.

Developing an ROI for PrEP

Multiple experts on the steering committee noted the importance of developing return on investment (ROI) data on PrEP to help inform benefit and financing discussions among State Medicaid agencies, MCOs, and other PrEP stakeholders.

ROI can be conceptualized at two levels: the ROI for PrEP overall, and the marginal ROI for optimal PrEP care that includes all recommended clinical services. The former is important for consideration of overall PrEP uptake; the latter may be useful in promoting policy changes to specifically ensure that Medicaid programs and MCOs are covering STI labs and other clinical PrEP services. In addition, information about the likely timeline in which ROI would be realized would help Medicaid agencies and MCOs understand if they are likely to see the savings themselves.

An important factor to consider in PrEP ROI is that a high proportion of PrEP users are likely to be "expansion enrollees" for whom the vast majority of Medicaid costs are borne by the federal government. For these adults, the federal government pays an FMAP starting at 100 percent and ramping down to 90 percent. For most states, this is far higher than the usual FMAP. Therefore, from the state perspective, the marginal costs of PrEP medication and clinical services are likely to be heavily discounted for expansion enrollees.[144] Of course, any financial savings from PrEP would be similarly discounted for the state.

MCOs, receiving fixed rates from the state per enrollee, would also be concerned about ROI. In states where one issuer dominates the Medicaid MCO market, cost-effectiveness arguments might be particularly effective because that issuer is more likely to see any savings achieved.[145] As noted above, in states where pharmacy or HIV drugs are carved out of MCO contracts, the ROI for PrEP would be less relevant for MCOs.

The financial ROI for PrEP may evolve over time, both as generics becomes available and as more information emerges regarding intermittent use models.

Conclusion

The Medicaid program is complex, offering a broad range of both challenges and opportunities for delivery of PrEP medication and clinical services. The levers and examples discussed in this white paper, along with the accompanying paper on Medicaid patient and provider engagement, should serve as a starting point for conversations about how Medicaid agencies and MCOs can work with public health to increase access, reduce HIV transmission, and promote the health of PrEP users.

Appendix 1: Project Steering Committee

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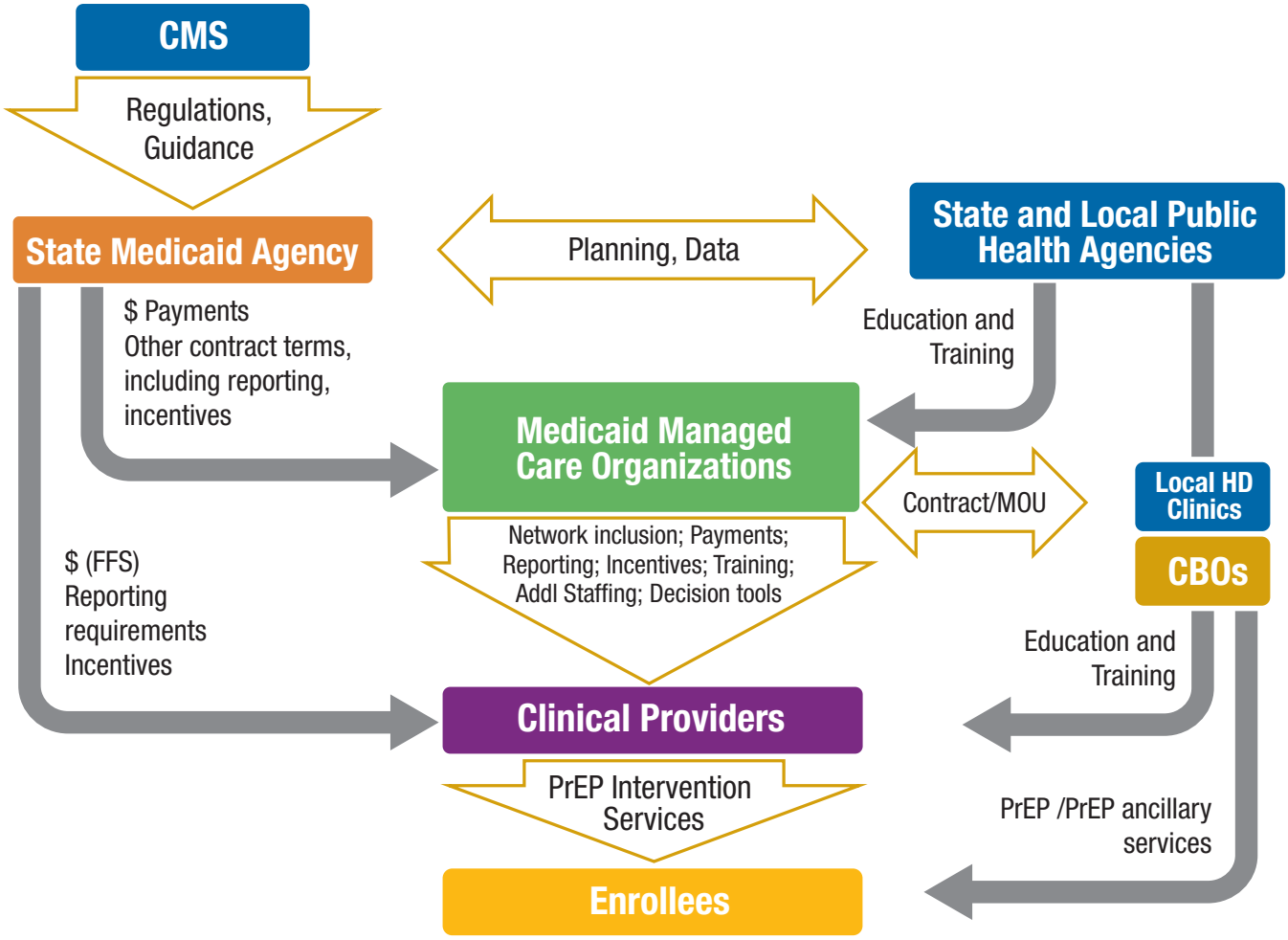
Appendix 2: Schematic of Medicaid Financing Levers



Endnotes

1. Siegler AJ, et al., The prevalence of pre-exposure prophylaxis use and the pre-exposure prophylaxiseto-need ratio in the fourth quarter of 2017, United States, Annals of Epidemiology (2018), https://doi.org/10.1016/j.annepi
2. CDC, "HIV prevention pill not reaching most Americans who could benefit – especially people of color" (Mar. 2018). www.cdc.gov/nchhstp/newsroom/
3. See, e.g., California HIV/AIDS Research Program, "Addressing PrEP Disparities Among Young Gay and Bisexual Men in California" (Sep. 2016). https://
4. Goldstein et al., "Being PrEPared — Preexposure Prophylaxis and HIV Disparities." New England Journal of Medicine (Sept. 19, 2018). www.nejm.org/doi/
5. AIDSMAP, "PrEP use growing in US, but not reaching all those in need" (Mar. 7, 2018). www.aidsmap.com/PrEP-use-growing-in-US-but-not-reaching-all-
6. See, e.g., Matthew A Spinelli, Hyman M Scott, Eric Vittinghoff, Albert Y Liu, Alicia Morehead-Gee, Rafael Gonzalez, Susan P Buchbinder; Provider Adherence to Pre-exposure Prophylaxis Monitoring Guidelines in a Large Primary Care Network, *Open Forum Infectious Diseases*, Volume 5, Issue 6, 1 June 2018, ofy099, https://doi.org/10.1093/ofid/ofy099
7. CDC, "PrEP" (Updated Aug. 23, 2018). www.cdc.gov/hiv/basics/prep.html
8. ANDA Approval Letter from FDA to Teva Pharmaceuticals USA, Inc. (June 8, 2017). www.accessdata.fda.gov/drugsatfda_docs/appletter/2017/090894Orig1s
9. ANDA Approval Letter from FDA to Amneal Pharmaceuticals of NY (Aug. 22, 2018). www.accessdata.fda.gov/drugsatfda_docs/appletter/2018/209721Orig1s
10. CDC, "Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update: A Clinical Practice Guideline." " (Published online Mar. 2018). https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guide
11. Gilead, "Truvada for PrEP Medication Assistance Program." www.gilead.com/responsibility/us-patient-access/truvada%20for%20prep%20medication%20assistance%20program
12. Washington State Department of Health, "Pre-Exposure Prophylaxis Drug Assistance Program (PrEP DAP)." www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/Prevention/PrEPDAP
13. New York State Department of Health, "PrEP Patient Assistance Program (PrEP-AP)." www.health.ny.gov/diseases/aids/general/prep/prep-ap_provider.htm
14. DC Department of Health, "Pre Exposure Prophylaxis Drug Assistance Program (PrEP DAP)." https://dchealth.dc.gov/DCPrEPDAP
15. Kaiser Family Foundation, "Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults" (Mar. 2018). www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/
16. *Id*.
17. Kaiser Family Foundation, "Medicaid Eligibility through the Aged, Blind, Disabled Pathway" (Jan. 2017). Nine states apply state-specific eligibility standards; see www.kff.org/medicaid/state-indicator/medicaid-eligibility-through-the-aged-blind-disabled-pathway/
18. Kaiser Family Foundation, "Health Coverage of Immigrants" (Dec. 2017). www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/
19. Exceptions include certain emergency services for undocumented immigrants. In addition, some states have chosen to use their CHIP programs to cover otherwise ineligible pregnant women who are immigrants.

20. Kaiser Family Foundation, "Current Status of State Medicaid Expansion Decisions" (Jul. 2018). www.kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/
21. MACPAC, "Medicaid enrollment changes following the ACA." www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/. The remaining "non-newly eligible" enrollees were adults who would have been eligible for Medicaid through pre-ACA pathways.
22. Lindsey Dawson, Jennifer Kates, and Anthony Damico, The Affordable Care Act and Insurance Coverage Changes by Sexual Orientation (Washington, DC: Kaiser Family Foundation, January 2018), www.kff.org/disparitiespolicy/issue-
23. McMorrow, Kenney, Long, and Anderson, "Uninsurance Among Young Adults Continues to Decline, Particularly in Medicaid Expansion States," Health Affairs 34, no. 4 (April 2015): 616-620.
24. Kaiser Family Foundation, "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review" (Mar. 2018). www.kff.
25. Coverage of Truvada through a family planning expansion would arguably be *permitted* under federal law, given that PrEP is as "related" to family planning as STI screening and treatment. However, the author did not identify current examples of states including this coverage. California has been asked to add PrEP to its program, but in an August 2017 Family Planning Stakeholder Meeting, explained: "The Family PACT program covers HIV screening only. The request has been presented to the Department before and given the fact that the FPACT program focuses on family PACT planning and family planning related needs, there are no plans to add additional benefits related to HIV beyond screening. Truvada PrEP is an HIV prevention strategy and we do not see it in the realm of family planning. While individuals who come in may be screened for HIV under FPACT, the use of Truvada PrEP is more encompassing and requires periodic monitoring by a provider. Within the scope of sexually transmitted infection testing under FPACT, we do provide very limited services from a prevention/treatment perspective and from the family planning lens; we do not see the use Truvada PrEP as falling into the same category." California Department of Health Care Services, "Family Planning Stakeholder Meeting [powerpoint slides" (Aug. 2017). www.dhcs.ca.gov/services/ofp/Documents/8.22.17PPT_FINAL.pdf.
26. Interview with Laura Beauchamps, August 16, 2018.
27. Kaiser Family Foundation, "States That Have Expanded Eligibility for Coverage of Family Planning Services Under Medicaid" (Jun. 2017). www.kff.org/medicaid/state-indicator/family-planning-services-waivers/
28. Guttmacher Institute, "Medicaid Family Planning Eligibility Expansions" (Updated Sep. 2018). www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions
29. *Id.*
30. Kaiser Family Foundation, "States That Have Expanded Eligibility for Coverage of Family Planning Services Under Medicaid" (Jun. 2017). www.kff.org/medicaid/state-indicator/family-planning-services-waivers/
31. Kaiser Family Foundation, "State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings November 2009" kaiserfamily-foundation.files.wordpress.com/2013/01/8015.pdf
32. *Id.*
33. Kaiser Family Foundation, "Payment and Coverage for the Prevention of Sexually Transmitted Infections (STIs)" (Nov. 2017). www.kff.org/womens-health-policy/fact-sheet/payment-and-coverage-for-the-prevention-of-sexually-transmitted-infections-stis/
34. MACPAC, "Types of Managed Care Arrangements." www.macpac.gov/subtopic/types-of-managed-care-arrangements/
35. 42 CFR 438.206 - Availability of services.
36. Mathematica for CMS, "Medicaid Managed Care Enrollment and Program Characteristics, 2016" (2018). www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2016-medicaid-managed-care-enrollment-report.pdf
37. Kaiser Family Foundation, "Medicaid Managed Care Penetration Rates by Eligibility Group" (Jul., 2017). www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/?activeTab=map
38. *Id.*
39. Kaiser Family Foundation, "Total Medicaid MCOs" (Mar. 2018). www.kff.org/medicaid/state-indicator/total-medicaid-mcos/
40. Kaiser Family Foundation, "Medicaid MCO Enrollment" (Mar. 2018). www.kff.org/other/state-indicator/medicaid-enrollment-by-mco/
41. See, e.g., "CMS Leverages Medicaid Program to Combat the Opioid Crisis" (June 2017). https://www.cms.gov/newsroom/press-releases/cms-leverages-medicaid-program-combat-opioid-crisis
42. CMS, "2018-2019 Medicaid Managed Care Rate Development Guide" (May 2018). www.medicaid.gov/medicaid/managed-care/downloads/guidance/2019-medicaid-rate-guide.pdf
43. MACPAC "Payment Policy in Medicaid Managed Care." *MACPAC Report to Congress* (June 2011). www.macpac.gov/wp-content/uploads/2015/01/Payment_Policy_in_Medicaid_Managed_Care.pdf
44. Mile High Healthcare Analytics, "Risk Adjustment in Medicaid" (2016). www.healthcareanalytics.expert/risk-adjustment-medicaid/
45. Interview with Doug Wirth, September 17, 2018.
46. Interview with David Rzeszutko, August 15, 2018.
47. Kaiser Family Foundation and NAMD, "Medicaid Moving Ahead in October 2017 Uncertain Times Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018" (Oct. 2017). http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018. Most commonly "carved out" benefits are behavioral health benefits, though there is a trend in behavioral health toward states "carving back in" some such services.
48. *Id.*
49. Interview with Mike Wofford, August 30, 2018.
50. Michigan Association of Community Mental Health Boards, "Membership: PIHP." https://macmhb.org/membership/pihp
51. Interview with David Rzeszutko, August 15, 2018.
52. Kaiser Family Foundation, "Share of Medicaid Population Covered under Different Delivery Systems" (Jul. 2017). www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/
53. American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA), "Joint Principles of the Patient-Centered Medical Home" (2007). www.acponline.org/system/files/documents/running_practice/delivery_and_payment_models/pcmh/demonstrations/jointprinc_05_17.pdf
54. Kaiser Family Foundation, "States that Reported Patient Centered Medical Homes In Place (SFY 2015-2017)." www.kff.org/medicaid/state-indicator/states-that-reported-patient-centered-medical-homes-in-place/
55. For the first two years, states received an enhanced 90% federal match for these six services; states then have considerable flexibility in how they pay health home providers, with most using a per member/per month rate.
56. CMS, "State-by-State Health Home State Plan Amendment Matrix" (Updated Apr. 2018). www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/state-hh-spa.pdf
57. Center for Health Care Strategies, "Medicaid Accountable Care Organizations: State Update" (Feb. 2018). www.chcs.org/media/ACO-Fact-Sheet-02-27-2018-1.pdf
58. *Id.*
59. AcademyHealth interview with Doug Wirth, June 11, 2018.
60. CMS, "Accountable Health Communities Model." innovation.cms.gov/initiatives/ahcm/
61. National Academy for State Health Policy, "State Levers to Advance Accountable Communities for Health" (May 2016). nashp.org/state-levers-to-advance-accountable-communities-for-health/
62. 42 CFR 438.206 - Availability of services.
63. HealthHIV, "Assessment of Medicaid Coverage of HIV/AIDS Prevention,

Screening, and Care Services: A Ten-State Review" (2015). targethiv.org/sites/default/files/file-upload/resources/HealthHIV%20Medicaid%20Prevention%20Care%20Assessment%202016.pdf

64. Interview with Mike Wofford and Sandra Robinson, August 31, 2018.
65. AcademyHealth Interview with DeAnn Gruber, May 23, 2018.
66. Medicaid.gov, "Telemedicine." www.medicaid.gov/medicaid/benefits/telemed/index.html
67. Center for Connected Health Policy, "50 State Scan of Telehealth Reimbursement Laws and Medicaid Policies – Factsheet" (2018). www.cchpca.org/sites/default/files/resources/50%20State%20Factsheet%20Spring%202018%20FI
68. *Id.*
69. Kaiser Family Foundation, Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans" (Mar. 2018). www.kff.org/report-section/medicaid-managed-care-plans-and-access-to-care-provider-networks-and-access-to-care/
70 Peter Wehrwein, "Q&A: A Interview with Henry DePhillips, MD: The Doctor in the Teladoc House" (April 2017). www.managedcaremag.com/archives/2017/4/Interview-henry-dephillips-md-doctor-teladoc-house
71. See www.nurx.com/prep and https://prep.plushcare.com.
72. Responses to AcademyHealth survey, October 2018.
73. See, e.g., New York State's Medicaid PA requirement for Truvada at https://newyork.fhsc.com/providers/CDRP_truvada.asp; interviewees from the state did not cite this requirement as a barrier to access.
74. Doug Wirth, Steering Committee Kickoff Call, May 9, 2018.
75. Kaiser Family Foundation and NAMD, "Medicaid Moving Ahead in Uncertain Times:Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018" (Oct. 2017). http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018
76. CDC, "Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update: A Clinical Practice Guideline." " (Published online Mar. 2018). https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf
77. Interview with Divya Ahuja, MD, August 9, 2018.
78. Interview with John Carlo, August 22, 2018.
79. AcademyHealth Interview with DeAnn Gruber, May 23, 2018.
80. CDC, "Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update – Clinical Providers' Supplement" (Published online Mar. 2018). www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-provider-supplement-2017.pdf
81. Kaiser Family Foundation, "Medicaid Coverage of Family Planning Benefits: Results From a State Survey" (Sep. 2016). files.kff.org/attachment/Report-Medicaid-Coverage-of-Family-Planning-Benefits-Results-from-a-State-Survey
82. NASTAD, "Financing HIV Prevention Services: Collaboration and Innovation between Public Health and Medicaid Agencies; Case Study: Rhode Island" (Feb. 2016). www.nastad.org/sites/default/files/resources/docs/NASTAD-HIV-Prevention-Rhode-Island-Case-Study.pdf
83. Rhode Island Medicaid, "Provider Reference Manual: Targeted HIV Medicaid Care/Case Management" (Mar. 2017). www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/MA%20Reference%20Guides/HIV%20Providers/HIV_TCM_Manual.pdf
84. NASTAD, "Billing Coding Guide for HIV Prevention: PrEP, Screening, and Linkage Services" (2016). www.nastad.org/resource/billing-coding-guide-hiv-prevention
85. Interview with Sara Rosenbaum, August 14, 2018.
86. Interview with Jennifer Babcock, August 22, 2018.
87. Kaiser Family Foundation "Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans" (Mar. 2018). www.kff.org/report-section/medicaid-managed-care-plans-and-access-to-care-provider-payment-and-delivery-system-reform/
88. NASTAD, "Billing Coding Guide for HIV Prevention: PrEP, Screening, and Linkage Services" (2016). www.nastad.org/resource/billing-coding-guide-hiv-prevention
89. USPSTF, "Draft Recommendation Statement: Prevention of Human Immunodeficiency Virus (HIV) Infection: Pre-Exposure Prophylaxis" (Nov. 2018). https://www.uspreventiveservicestaskforce.org/Page/Document/draft-recommendation-statement/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis
90. CDC, "Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update – Clinical Providers' Supplement" (Published online Mar. 2018). www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-provider-supplement-2017.pdf
91. Interview with Stephen Cha, August 6, 2018.
92. MACPAC "Payment Policy in Medicaid Managed Care." *MACPAC Report to Congress* (June 2011). www.macpac.gov/wp-content/uploads/2015/01/Payment_Policy_in_Medicaid_Managed_Care.pdf
93. Kaiser Family Foundation and NAMD, "Medicaid Moving Ahead in October 2017 Uncertain Times Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018" (Oct. 2017). http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018
94. Interview with David Rzeszutko, August 15, 2018.
95. National Association for State Health Policy, "Tennessee: Using Managed Care Incentivesto Improve Preventive Services and Care for Children" (Jan. 2018). https://nashp.org/wp-content/uploads/2018/01/Tennessee-Case-Study-2018.pdf
96. Kaiser Family Foundation, "Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016" (Oct. 2015). www.kff.org/report-section/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-managed-care-reforms/
97. Interview with Matt Salo, August 20, 2018.
98. Interview with Stephen Cha, August 6, 2018.
99. Kaiser Family Foundation "Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans" (Mar. 2018). (https://www.kff.org/report-section/medicaid-managed-care-plans-and-access-to-care-provider-payment-and-delivery-system-reform/
100. Id.
101. Interview with Dr. John Carlo, August 22, 2018.
102. See, e.g., Delbanco, "The Current Evidence for Bundled Payments" (Apr. 30, 2018). https://www.ajmc.com/contributor/suzanne-delbanco/2018/04/the-current-evidence-for-bundled-payment
103. Kaiser Family Foundation, "CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions" (June 2016). www.kff.org/report-section/cmss-final-rule-on-medicaid-managed-care-issue-brief/
104. Weiss G, Smith DK, Newman S, Wiener J, Kitlas A, Hoover KW (2018) PrEP implementation by local health departments in US cities and counties: Findings from a 2015 assessment of local health departments. PLoS ONE 13(7): e0200338. https://doi.org/10.1371/journal.pone.0200338
105. *Id.*
106. Interview with Gretchen Weiss, August 17, 2018.
107. *Id.*
108. Leichliter JS, Seiler N, Wohlfeiler D. STD Prevention Policies in the United States: Evidence and Opportunities. Sexually transmitted diseases. 2016;43(2 Suppl 1):S113-S121. doi:10.1097/OLQ.0000000000000289. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5283689/
109. Interview with Gretchen Weiss, August 17, 2018.
110. AcademyHealth Interview with Katie Macomber, MI.
111. HRSA, "Sexually Transmitted Disease Clinics." www.hrsa.gov/opa/eligibility-and-registration/specialty-clinics/sexually-transmitted-disease/index.html.
112. NASTAD, "Financing HIV Prevention Services: Collaboration and Innovation between Public Health and Medicaid Agencies: Chicago Case Study" (Feb.

2016). www.nastad.org/sites/default/files/resources/docs/NASTAD-HIV-Prevention-Chicago-Case-Study.pdf

113. AIDS United, "Monetization of HCBO Functions: 6-Part Webinar Series." www.aidsunited.org/webinars/monetization-of-aso-functions-building-a-strong-relationship-with-the-payer-community
114. Association of Community Health Plans, "Partnerships that Strengthen the Safety Net" (2017). www.communityplans.net/wp-content/uploads/2017/06/2017-STSNA-Nominations-Fact-Sheet-FINAL.pdf
115. STATE OF MICHIGAN Contract No.[ ] Comprehensive Health Care Program for the Michigan Department of Health and Human Services. www.michigan.gov/documents/contract_7696_7.pdf
116. Interview with David Rzeszutko, August 15, 2018.
117. *Id.*
118. Scope of Practice Policy, "Nurse Practitioners Overview: Prescriptive Authority." http://scopeofpracticepolicy.org/practitioners/nurse-practitioners/
119. Scope of Practice Policy, "Physician Assistants Overview: Prescriptive Authority." http://scopeofpracticepolicy.org/practitioners/physician-assistants/
120. Kaiser Family Foundation, "Medicaid Benefits: Nurse Practitioner Services" (2012). https://www.kff.org/medicaid/state-indicator/nurse-practitioner-services/
121. *Id.*
122. Interview with Melody Wilkinson, August 22, 2018.
123. American Academy of PAs, "Third-Party Reimbursement for PAs" (Apr. 2018). https://www.aapa.org/wp-content/uploads/2017/01/Third_party_payment_2017_FINAL.pdf
124. Interview with Douglas Krakower, August 8, 2018.
125 Interview with Jason Farley, August 9, 2018.
126 AH Interview with Lyn Stevens (June 5, 2018).
127 AH Interview with Katie Macomber, Michigan (May 24, 2018); Interview with Melody Wilkinson, August 22, 2018.
128. Walgreens, "Learn About PrEP." https://www.walgreens.com/topic/pharmacy/healthcare-clinic.jsp
129. Tung et al., "Feasibility of a Pharmacist-Run HIV PrEP Clinic in a Community Pharmacy Setting" (CROI 2018). http://www.croiconference.org/sessions/feasibility-pharmacist-run-hiv-prep-clinic-community-pharmacy-setting
130. *Id.*
131. *Id.*
132. Cody Shafer, "Pharmacist-Partnered PrEP Delivery." https://www.nastad.org/sites/default/files/Mega-Meeting-Slides/pharmacy-based_hiv-hcv_prevention_delivery_-_cody_shafer.pdf
133. *Id.*
134. National Conference of State Legislatures, "Medication Therapy Management: Pharmaceutical Safety and Savings" (Updated Oct. 2016). http://www.ncsl.org/research/health/medication-therapy-management.aspx
135. HRSA, "What is a Health Center?" https://bphc.hrsa.gov/about/what-is-a-health-center/index.html.
136. MACPAC. Medicaid Payment Policy for Federally Qualified Health Centers (Dec. 2017). https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf
137. CMCS Informational Bulletin: State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception (Apr. 2016). https://www.medicaid.gov/federal-policy-guidance/downloads/cib040816.pdf
138. Kaiser Family Foundation, "Medicaid Benefits: Rural Health Clinic Services" (2012). https://www.kff.org/medicaid/state-indicator/rural-health-clinic-services/
139. Interview with Erin Loubier, Juan-Carlos Loubriel, and Megan Coleman, August 7, 2018.
140. Interview with Sara Rosenbaum, August 14, 2018.
141. Interview with Erin Loubier, Juan-Carlos Loubriel, and Megan Coleman, August 7, 2018.
142. Interview with Leighton Ku, September 5, 2018.
143. *Id.*
144. Interview with Matt Salo, August 20, 2018.
145. Interview with Stephen Cha, August 6, 2018.
146. AcademyHealth interview with Doug Wirth, June 11, 2018.
147. Press Release, "NYS Medicaid Special Needs Health Plans (SNPs) to Expand Access to All Medicaid-Eligible Transgender Individuals Regardless of HIV Status" (Nov. 1, 2017). mysocialgoodnews.com/nys-medicaid-special-needs-health-plans-snps-expand-access-medicaid-eligible-transgender-individuals-regardless-hiv-status/
148. AcademyHealth interview with Doug Wirth, June 11, 2018.
149. *Id.*
150. National Coalition of STD Directors, "Extragenital Testing" (April 2017). www.ncsddc.org/resource/extragenital/
151. Health Management Associates for the Association for Community-Affiliated Plans, "Strategies to Increase MAT Prescribing" (May 2018). https://www.communityplans.net/research/strategies-to-increase-mat-prescribing/
152. Interview with Jennifer Babcock, August 22, 2018
153. Schulman et al., "Exploring Value-Based Payment to Encourage Substance Use Disorder Treatment in Primary Care" (June 2018). https://www.chcs.org/media/VBP-for-SUD_Final_June-2018.pdf

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From: Close, Natasha (DOH)
Sent: 1/17/2019 11:59:00 AM
To: Coletta, Michael A. (CDC/DDPHSS/CSELS/DHIS)
Cc:
Subject: RE: video


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attachments\C28C26DBF8554B9D_image002.png

They put it in the January NSSP Update so all of us could enjoy! ;-) I thought you were better than Chesley. His responses to your answers were so short and scripted sounding.

Yeah, hard to make those things seem like a natural conversation.

From: Coletta, Michael A. (CDC/DDPHSS/CSELS/DHIS) [mailto:mac0@cdc.gov]
Sent: Thursday, January 17, 2019 11:57 AM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Subject: RE: video

Ha! I don't remember sending that along. But – the back story is the first take was MUCH better, unfortunately they didn't capture the audio. The second take I was super nervous and trying to recall what I had said the first time.

Glad I could bring you a chuckle. Being in front of the camera like that is quite difficult.

Sincerely,

Michael A. Coletta, MPH
National Syndromic Surveillance Program Manager
Division of Health Informatics and Surveillance
Center for Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention
404-498-2332
mac0@cdc.gov
"Working together on big ideas"

http://www.cdc.gov/ophss/csels/dhis/
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From: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Sent: Thursday, January 17, 2019 1:05 PM
To: Coletta, Michael A. (CDC/DDPHSS/CSELS/DHIS) <mac0@cdc.gov>
Subject: RE: video

https://www.youtube.com/watch?v=Vcr1se-Y6q8

From: Coletta, Michael A. (CDC/DDPHSS/CSELS/DHIS) [mailto:mac0@cdc.gov]
Sent: Thursday, January 17, 2019 3:19 AM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Subject: Re: video

Which video?

Michael A. Coletta, MPH
National Syndromic Surveillance Program Manager
CDC/CSELS/DHIS
mac0@cdc.gov
www.cdc.gov/nssp

Sent via mobile device - please excuse brevity and tone.

From: "Close, Natasha (DOH)" <Natasha.Close@DOH.WA.GOV>
Sent: Wednesday, January 16, 2019 7:31 PM
To: "Coletta, Michael A. (CDC/DDPHSS/CSELS/DHIS)" <mac0@cdc.gov>
Subject: video
OMG…that YouTube video you did on surveillance had me cracking up. Thanks for sharing that, I needed it!

Natasha Close, MPH
Surveillance Epidemiologist
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_____
From: Close, Natasha (DOH)
Sent: 1/17/2019 11:32:00 AM
To: Loschen, Wayne A.,Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR)
Subject: RE: All Traffic Related v2 CCDD Category

Yay! So excited!!!!! Thanks!

Natasha

From: Loschen, Wayne A. [mailto:Wayne.Loschen@jhuapl.edu]
Sent: Thursday, January 17, 2019 11:27 AM
To: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Got it – thanks.

Wayne

Wayne Loschen
Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

From: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Sent: Thursday, January 17, 2019 2:05 PM
To: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>
Cc: Close, Natasha (CDC doh.wa.gov) <natasha.close@doh.wa.gov>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: All Traffic Related v2 CCDD Category

Wayne,

Please find Natasha's All Traffic Related v2 in the attached document. Please let me know if you have any questions about it.

Thank you!
Zach

ZACHARY STEIN, MPH
Syndromic Surveillance Analyst
ICF Contractor, BioSense Platform
Center for Surveillance, Epidemiology, and Laboratory Services
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From: Cooper, Kelly (DOH)
Sent: 1/18/2019 10:57:34 AM
To: Wiesman, John (DOH),scott.merriman@ofm.gov.gov
Subject: FW: Z-0126.7 from Code Reviser's Office

attachments\D6AF1CAD45F14FD4_Z-0126.7.doc

attachments\2ED4BE968A2E4EDF_Z-0126.7.pdf

Here is the new fphs bill from the code reviser.

From: Lawson, Brook (DOH)
Sent: Friday, January 18, 2019 10:13 AM
To: Cooper, Kelly (DOH) <Kelly.Cooper@DOH.WA.GOV>; Black, Ryan (DOH) <Ryan.Black@DOH.WA.GOV>
Subject: FW: Z-0126.7 from Code Reviser's Office
Importance: High

Available at the CR.

From: Braatz, Jessica [mailto:Jessica.Braatz@leg.wa.gov]
Sent: Friday, January 18, 2019 9:42 AM
To: Lawson, Brook (DOH) <Brook.Lawson@DOH.WA.GOV>
Subject: Z-0126.7 from Code Reviser's Office

Signature sheet is ready for pick-up at the Code Reviser's Office.

From: Promoting Interoperability TaskForce
Sent: 1/16/2019 1:00:46 PM
To: CDC-PH-INTEROPERABILITYTASKFORCE@LISTSERV.CDC.GOV
Cc:
Subject: AIRA Comments on Reducing Provider Burden

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Greeting Task Force Members,

Thank so much Mary Beth for sharing your comments with the task force. We hope that the attachments can assist with creating comments on behalf of the task force.

Kindly note that we would like to request participation and comments from task members on the proposed strategy documentation. Steve and Mary Beth discussed a few additional comments that could be submitted by the task force.

Thank you all for your continued participation.

CDC/CSELS EHR Meaningful Use Team

Sanjeev Tandon MBBS, MD, MS
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Nina L. Mitchell BS, MS Heath Informatics
CDC/CSELS Public Health & Promoting Interoperability Programs (formerly, known as EHR Meaningful Use) Team
Chenega Corporation-Expert Consultant
Center for Surveillance, Epidemiology and Laboratory Services (CSELS)
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS E-94, Atlanta, GA 30333

To submit questions or request technical assistance for Public Health issues related to the Electronic Health Record (EHR) Meaningful Use Incentive Programs please contact us at:meaningfuluse@cdc.gov

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link:
http://listserv.cdc.gov/scripts/wa.exe?SUBED1=CDC-PH-INTEROPERABILITYTASKFORCE&A=1

From: Mitchell, Nina (CDC/DDPHSS/CSELS/OD) (CTR)
Sent: 1/16/2019 7:19:30 AM
To: Baumgartner, Chris J (DOH),Nelson, Ramona (DOH)
Subject: RE: Opioid Crisis Grant - RHINO TA Request

attachments\4AA0378B20B34A0F_image008.png
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attachments\505BEAC44D124208_image011.png
attachments\86E0904E43ED406F_image009.png
attachments\D26B1876E99D4DE5_image005.png
attachments\2A376A99F27545A7_image003.png
attachments\E490E3DA5B474E3D_image010.png
attachments\FD2B77DB24314444_image013.png
attachments\5D691A1489FB4959_image007.png

Greeting Chris,

Our ONC colleagues are addressing the issue. The last update was that Dan Chaput who had a few follow-up questions to be addressed by r either you or Brian. So that we can address the issue I will send an invite for Wed, Jan 23: 8:00–9:00 a.m. PT (11:00 a.m.–12:00 p.m. ET

Thanks for your patience as we work to find a resolution.

Nina L. Mitchell BS, MS Health Informatics
Chenega Corporation-Expert Consultant
CDC, Center for Surveillance, Epidemiology and Laboratory Services (CSELS)
Century Center, Bldg 2400 RM 6401.06
Atlanta, Georgia 30345, MS E-94
Phone 404-498-6558- Email nai7@cdc.gov

To submit questions or request technical assistance for Public Health issues related to the Electronic Health Record (EHR) Meaningful Use Incentive Programs please contact us at:meaningfuluse@cdc.gov

From: Baumgartner, Chris J (DOH) <Chris.Baumgartner@DOH.WA.GOV>
Sent: Tuesday, January 15, 2019 4:52 PM
To: Nelson, Ramona (DOH) <Ramona.Nelson@DOH.WA.GOV>; Mitchell, Nina (CDC/DDPHSS/CSELS/OD) (CTR) <nai7@cdc.gov>
Cc: Chaput, Daniel (OS/ONC) <Daniel.Chaput@hhs.gov>; Karras, Bryant (CDC doh.wa.gov) <bryant.karras@doh.wa.gov>; Wickersham, Kevin P (DOH) <kevin.wickersham@doh.wa.gov>
Subject: RE: Opioid Crisis Grant - RHINO TA Request

Nina I'm not sure we ever heard back on dates/times that worked for ONC.

Are we able to still set this up next week?

Thanks,

Chris Baumgartner
Senior Data Exchange Manager
Office of the State Health Officer
Washington State Department of Health
chris.baumgartner@doh.wa.gov
206-418-5530 | www.doh.wa.gov
<https://www.doh.wa.gov/Newsroom/SocialMedia>

From: Nelson, Ramona (DOH)
Sent: Friday, January 4, 2019 2:11 PM
To: nai7@cdc.gov
Cc: Chaput, Daniel (OS/ONC) (Daniel.Chaput@hhs.gov) <Daniel.Chaput@hhs.gov>; Baumgartner, Chris J (DOH) <Chris.Baumgartner@DOH.WA.GOV>; Karras, Bryant T (DOH) <Bryant.Karras@DOH.WA.GOV>; Wickersham, Kevin P (DOH) <kevin.wickersham@doh.wa.gov>
Subject: RE: Opioid Crisis Grant - RHINO TA Request

Hi Nina,

The following dates/times are available during the week of January 21 for a one-hour DOH/ONC phone meeting:

Tue, Jan 22: 12:00–1:00 p.m. PT (3:00–4:00 p.m. ET)
Wed, Jan 23: 8:00–9:00 a.m. PT (11:00 a.m.–12:00 p.m. ET)
Thu, Jan 24: 12:00–1:00 p.m. PT (3:00–4:00 p.m. ET)

Please let us know if one of these dates/times will work with ONC staffs' schedules.

Thank you very much,
Ramona

Ramona Nelson
Executive Assistant
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<https://twitter.com/wadepthealth?lang=en>
<https://www.facebook.com/WADeptHealth/>
<https://www.instagram.com/wadepthealth/>
<https://www.youtube.com/channel/UCTSCpezTD0TjiiAOuJY7f5w/doh>
<https://medium.com/@WADeptHealth>

From: Chaput, Daniel (OS/ONC)
Sent: Thursday, January 3, 2019 5:59 PM
To: 'Baumgartner, Chris J (DOH)'
Cc: Karras, Bryant T (DOH); Abbey, Rachel (OS/OSCP); Daniel, James B. (HHS/CTO); Mitchell, Nina (CDC/DDPHSS/CSELS/OD) (CTR); Wickersham, Kevin P (DOH)
Subject: RE: Opioid Crisis Grant - RHINO TA Request

Up to you. Either way I may ask for a bit more technical detail or time/date details, but there is quite a bit here. We may also meet with the vendor first, as a courtesy and to allow them a chance to address the issues from their perspective.

Dan

Daniel Chaput
202.260.0368 (Office)/202.746.9471 (Cell)
See my availability here.

From: Baumgartner, Chris J (DOH)
Sent: Thursday, January 3, 2019 5:48 PM
To: Chaput, Daniel (OS/ONC)
Cc: Karras, Bryant T (DOH); Abbey, Rachel (OS/OSCP); Daniel, James B. (HHS/CTO); Mitchell, Nina (CDC/DDPHSS/CSELS/OD) (CTR); Wickersham, Kevin P (DOH)
Subject: RE: Opioid Crisis Grant - RHINO TA Request

Ok. Should we pre-meet with just ONC & WA DOH before we rope in any EMR vendor?

Thanks,

Chris Baumgartner
Senior Data Exchange Manager
Office of the State Health Officer
Washington State Department of Health
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<https://www.doh.wa.gov/Newsroom/SocialMedia>

please contact the sender by reply e-mail and destroy the message."

From: Chaput, Daniel (OS/ONC)
Sent: Thursday, January 3, 2019 2:44 PM
To: Baumgartner, Chris J (DOH)
Cc: Karras, Bryant T (DOH); Abbey, Rachel (OS/OSCP); Daniel, James B. (HHS/CTO); Mitchell, Nina (CDC/DDPHSS/CSELS/OD) (CTR)
Subject: RE: Opioid Crisis Grant - RHINO TA Request

+Rachel, Jim, and Nina

Chris,

Yes, let's set up a call. I've cc'd Nina here who can help. Good that the customers are involved, and see that the issues lie with the vendors. Not sure I see anything that indicates their "certification" is the issue. Certification ensures they can produce a conformant message in a "test lab".

Things like having to wait for a major release to get an update out are not covered in certification. Neither is connectivity, which is left up to the states.

Often, just having ONC in on the discussion with the vendor gets to the root cause and can result in a fix. Don't see anything that represents something we might take action on.

I know with the WA NextGen issue the manager was messaging the implementation team and telling them how to fix the issue while we were on the phone. It is sometimes that easy.

Sounds like we should start with 1) AthenaHealth (since they are hospitals); 2) Allscripts because it just sounds like it needs another set of eyes and a bit of help; then 3) which sounds like it should be simple, but is the "smaller" volume. But will defer to you.

Dan

Daniel Chaput
202.260.0368 (Office)/202.746.9471 (Cell)
See my availability here.

From: Baumgartner, Chris J (DOH)
Sent: Thursday, January 3, 2019 5:09 PM
To: Chaput, Daniel (OS/ONC)
Cc: Karras, Bryant T (DOH)
Subject: RE: Opioid Crisis Grant - RHINO TA Request

Hi Dan:

Here are some answers from the SS team. Would you like me to set up a call with them? They are very open to it.

Active Engagement Option 2—Testing and Validation: The EP, EH, or CAH is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the public health agency or, where applicable, the clinical data registry within 30 days; failure to respond twice within an EHR reporting period would result in that Provider not meeting the measure.

We've been tracking our interactions with the providers/hospitals with respect to their responsiveness, and our facilities have been well engaged and responsive to us (with a

few exceptions unrelated to the issues we're discussing here). We've worked alongside the facilities to work with their vendors and have had a lot of success, with exception of the 3 groups below. Short of threatening the facilities who have been cooperative and helpful to us for the most part, which we're hesitant (understandably, I think) to do, I think we've exhausted our options which is what caused us to reach out for assistance.

I want to clarify also what I think we're asking for from ONC. It's my (our) belief, and maybe I'm wrong, that since these vendors have MU certified products we shouldn't be experiencing the issues we are with them. It also doesn't seem entirely clear that these vendors have much motivation to correct the issues we're seeing. It seems like ONC would be in a position to encourage (apply pressure) to these vendors to perform as needed. Is this something that could be done? The vendors are having an array of technical problems, to be sure, but it's our feeling that the root of the issue is political rather than technical. It seems to me that these issues could be resolved if the vendors were adequately motivated to do so.

Allscripts
In early January 2018 we received encrypted messages through PHINMS. Decrypted messages received in mid-January 2018. In February 2018 a pre-validation error report detailing errors in message structure and non-adherence to value sets was sent to Allscripts. No new messages since January 18, 2018. In August, a new batch of messages were received by DOH, but were encrypted once again. A software update to be released mid-October was supposed to rectify the encryption issue, but it wasn't released until December 6, 2018. DOH is awaiting test messages from one of the Allscripts facilities. A few of the Allscripts facilities have expressed their readiness to begin onboarding.
Clinics*

What are these getting encrypted with? Why? Doesn't the vendor have access to an the unencrypted messages that at least could be sent to verify format and content? Are these being encrypted in production but not test? Is this really test data or are we fooling around with production data in a test system (which is why the vendor might encrypt it)?

We have received proper HL7 messages from Allscripts in the past, but after installing an updated security certificate the messages arrived encrypted. Our Test and Production environments process messages identically, and we actually control which environment messages are sent to. In short, the basic function of transmitting messages to WA DOH has presented more challenges than we would normally expect for a vendor. Additionally, the fixes needed to address major data transmission problems have only been included in their normal "code promotions", which seems to occur very infrequently, and are often pushed back. The inability to fix these types of problems outside of a code push would be a huge setback for a facility that has reached production status. Extended outages that cannot be resolved until the next code promotion could really limit the utility of the data.

* Columbia Medical Associates, will send via PHINMS. Seven departments, each with unique physical location providing ambulatory care.
* Community Health of Central Washington will send via PHINMS. Five departments, each with unique physical address providing ambulatory care services.
* Kitsap Medical Group. Donald L. Sharman MD will send via PHINMS. One ambulatory care facility.
* Our Lady of Lourdes Health Center sending via PHINMS. Eighteen departments, nine unique physical locations providing ambulatory and urgent care services.
* Family Wellness Center sending via PHINMS. One ambulatory care department.
* Northeast Washington Health Programs. PHINMS. Eight departments, each with unique physical location providing ambulatory care services.
* Northwest Medical Specialties, PLLC sending via PHINMS. One facility offering

ambulatory and inpatient services.
* SeaMar Community Health Centers sending via PHINMS. Twenty-five departments, twenty-four unique physical locations providing ambulatory care services.
* The Seattle Indian Health Board sending via PHINMS. One location with ambulatory services.
* Walla Walla Clinic sending via PHINMS. Seven departments with four unique physical locations providing ambulatory services.

AthenaHealth
In June 2017 a GoToMeeting was held with AthenaHealth and DOH to discuss data connectivity. DOH encouraged use of the HIE, but offered SFT/PHINMS as alternate options. AthenaHealth responded in mid-August asking for a contact at OneHealthPort in case they had questions regarding the HIE connectivity option. In late-September Athena emailed that they could not support HIE as a connectivity option. DOH offered setting up an SFT connection in mid-October. In late January a new contact at Athena requested more information regarding SFT connectivity, and DOH responded that the connection was already set up and that DOH was ready to receive hourly batches of messages. No response was received (after monthly follow-up emails) until April 2018 at which time DOH suggested testing the connection, provided the messaging guide, and asked for a timeline. Athena replied this would occur by the end of April. DOH received numerous blank messages in July on two separate occasions. DOH received no response to monthly emails (since August) and on December 12, 2018 DOH called a Senior Associate of Integration Services at AthenaHealth who responded the next day that "this project has fallen off of our radar" and has since responded promptly to emails. AthenaHealth is working to complete message batching, asked to test the connection using Quincy Valley Medical Center, and asked DOH to confirm values for the MSH-4.1 and MSH-4.2 segments as of December 17, 2018. On December 18, 2018 AthenaHealth asked about OneHealthPort connectivity options.
Hospitals*

Why are hospitals participating (MU)? Is there an incentive? While in test and validation have they failed to respond per the incentive requirement and thus are not in "Active Engagement". Does the entity attesting understand that? What is the OneHealthport connection, SOAP?

Hospitals which have emergency departments are required to submit emergency department patient care information to comply with Washington State law RCW 43.70.057. This is in addition to participating in MU. We have not addressed the "active engagement" issue with the facilities, as the issues lie on the EHR vendor side. The facilities are responsive to us in large part, yet their vendors fail to meet their obligations. We did receive test files from them at the end of December so we have confirmation the connection is in place, but have not received HL7 messages yet. The primary issues appear to be the lack of technical expertise/experience with data transport, since the SFT transport option has been implemented by many other entities successfully. The OneHealthPort connection uses something called an AS2 protocol, which AthenaHealth is not capable of using. I am unfamiliar with SOAP connections, and whether AS2 is of this type.

* Quincy Valley Medical Center working to establish SFT transport method.
* Garfield County Memorial Hospital will send through SFT.
Clinics*
* Yakima HMA Physician Management, LLC will send through SFT. Fourteen departments, twelve unique physical locations providing ambulatory care.
* Rose Family Medicine, PLLC will send through SFT. One facility providing ambulatory and urgent care.
* Stepping Stone Pediatrics. Indicated SFT connectivity preference. One facility offering ambulatory services.

eClinicalWorks
In February 2017, eClinicalWorks facilities notified DOH that a connection through the OneHealthPort HIE was not possible, but they were successful in sending messages by an SFT connection. DOH received a batch of messages in July 2017 and regular transmission did not occur until September 2017. DOH stopped receiving messages again in October 2018. Email communication between DOH and an eClinicalWorks facility in late November prompted a response from eClinicalWorks that the issue would be elevated internally. On December 17, 2017 DOH received word that the eClinicalWorks developer team is working on the issue, but they did not provide a timeline.
Clinics*

Same as above re: what is the connection and why can't eClinical connect? Where are the hospitals and health centers in all this? Are they concerned stakeholders?

The connection here is SFTP. The clinics affected (approximately 20 entities) are concerned an involved, but evidently haven't been able to influence this much. Given that they are smaller facilities, we feel fortunate to have them willing to submit data to us and are hesitant to apply too much pressure to the facilities when it is their vendor causing the issues.

* Blue Mountain Family Health sending via SFT and awaiting validation. One facility providing ambulatory care.
* Edmonds Family Care sending via SFT and awaiting validation. One facility providing ambulatory care.
* Creekside Medical, PS sending via SFT and awaiting validation. One facility providing ambulatory care.
* Ken P. Lee sending via SFT and awaiting validation. One facility providing ambulatory care.
* Allcare Medical Clinic, Inc. registered and will use SFT. One facility providing ambulatory care.
* Richmond Pediatric Clinic, Inc. sending via SFT and awaiting validation. One facility providing ambulatory care.
* Auburn Family Medical Center sending via SFT and awaiting validation. One facility providing ambulatory care.
* Memorial Physicians Management sending via SFT and awaiting validation. One facility providing ambulatory care.

*Doesn't include excluded facilities

Sincerely,

Chris Baumgartner
Senior Data Exchange Manager
Office of the State Health Officer
Washington State Department of Health
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From: Chaput, Daniel (OS/ONC)
Sent: Wednesday, January 2, 2019 11:50 AM
To: Baumgartner, Chris J (DOH)
Cc: Karras, Bryant T (DOH)
Subject: RE: Opioid Crisis Grant - RHINO TA Request

All,

It appears to be that you may be able to use the incentive program stick here:

Active Engagement Option 2—Testing and Validation: The EP, EH, or CAH is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the public health agency or, where applicable, the clinical data registry within 30 days; failure to respond twice within an EHR reporting period would result in that Provider not meeting the measure.

If providers/hospitals are getting incentives without meeting the measure per above, you may want to speak with them. Not an EHR vendor issue. Let the entity getting the incentive tell the EHR what to do.

Any other thoughts from your end? Is this mandated reporting for opioids? Some other program? Seems like the actual providers are not fully engaged, although it may just not be there.

Shall we schedule a phone conference?

Dan

Daniel Chaput
202.260.0368 (Office)/202.746.9471 (Cell)
See my availability here.

From: Baumgartner, Chris J (DOH)
Sent: Monday, December 31, 2018 2:47 PM
To: Chaput, Daniel (OS/ONC)
Cc: Karras, Bryant T (DOH)
Subject: RE: Opioid Crisis Grant - RHINO TA Request

Here is some more detail form the SS team. Does this get you what you need?

"Long story short, the "real" issue is that we have 3 EHR vendors with which we've been working for years now who cannot send syndromic surveillance data to us. The healthcare entities affected are mostly ambulatory, however there are also 2 acute care hospitals waiting on Athena Health to connect with us. I believe all (or nearly all) of the affected entities are registered for MU.

Our team is spending a lot of resources trying to help these vendors transmit messages to no avail which is impacting our team, and we are also missing the data which would be transmitted from these clinics by these vendors for public health surveillance."

Thanks,

Chris Baumgartner
Senior Data Exchange Manager
Office of the State Health Officer
Washington State Department of Health
chris.baumgartner@doh.wa.gov

206-418-5530 | www.doh.wa.gov
<https://www.doh.wa.gov/Newsroom/SocialMedia>

From: Chaput, Daniel (OS/ONC)
Sent: Monday, December 31, 2018 10:37 AM
To: Baumgartner, Chris J (DOH)
Subject: RE: Opioid Crisis Grant - RHINO TA Request

I have also been working with Elyse Kadokura on a separate matter with NextGen. I seem to have that ironed out, just appears to be a bit of general confusion and I am not sure who is who, etc. Thanks, Dan

Daniel Chaput
202.260.0368 (Office)/202.746.9471 (Cell)
See my availability here.

From: Baumgartner, Chris J (DOH)
Sent: Monday, December 31, 2018 1:28 PM
To: Chaput, Daniel (OS/ONC)
Subject: RE: Opioid Crisis Grant - RHINO TA Request

Let me see what I can dig up.

Sincerely,

Chris Baumgartner
Senior Data Exchange Manager
Office of the State Health Officer
Washington State Department of Health
chris.baumgartner@doh.wa.gov
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<https://www.doh.wa.gov/Newsroom/SocialMedia>

From: Chaput, Daniel (OS/ONC)
Sent: Monday, December 31, 2018 6:39 AM
To: Baumgartner, Chris J (DOH)
Subject: FW: Opioid Crisis Grant - RHINO TA Request

Chris,

Your thoughts? I can't identify the "real" problem from the attached status.

Is this all ambulatory? Are they doing it for MU or part of another initiative, etc.?

Can't do much without a bit of detail.

Thanks,

Dan

Daniel Chaput
202.260.0368 (Office)/202.746.9471 (Cell)
See my availability here.

From: Wickersham, Kevin P (DOH)
Sent: Wednesday, December 19, 2018 4:59 PM
To: Chaput, Daniel (OS/ONC); Alvisurez, Jennifer (DOH)
Cc: Daniel, James B. (HHS/CTO); Abbey, Rachel (OS/OSCP); Tandon, Sanjeev (CDC/DDPHSS/CSELS/OD); Close, Natasha (DOH); Deutsch, Sarah L (DOH); Meade, Rachel L (DOH); Karras, Bryant T (DOH); Baumgartner, Chris J (DOH); Turner, Kali A (DOH)
Subject: RE: Opioid Crisis Grant - RHINO TA Request

Hi Daniel,

Thank you for the reminder and I apologize for the delay. I wanted to make sure we could assemble some detail for you. Please see the attached document for a description of the main issues we're facing with these vendors as well as the impacted facilities. These vendors have caused extensive delays to onboarding the listed facilities for syndromic surveillance which has impacted the surveillance utility and representativeness of our data.

Furthermore, as recently as this week, Allscripts has indicated that they are not able to connect to our HIE.

I've looped in our informatics team as well as our team's onboarding coordinator here and would be happy to provide additional information if desired.

Please let me know if there is anything we can do to help support efforts to bring these vendors on board for reporting.

Thanks and best,
Kevin

Kevin Wickersham, MS
Gender Pronouns: he/him
Preparedness and Response Unit Supervisor
Office of Communicable Disease Epidemiology
Division of Disease Control and Health Statistics
Washington State Department of Health
kevin.wickersham@doh.wa.gov
206-450-9827 | www.doh.wa.gov
<https://www.doh.wa.gov/Newsroom/SocialMedia>

From: Chaput, Daniel (OS/ONC)
Sent: Wednesday, December 19, 2018 1:53 PM
To: Alvisurez, Jennifer (DOH)
Cc: Daniel, James B. (HHS/CTO); Abbey, Rachel (OS/OSCP); Tandon, Sanjeev (CDC/DDPHSS/CSELS/OD); Close, Natasha (DOH); Wickersham, Kevin P (DOH); Deutsch, Sarah L (DOH); Meade, Rachel L (DOH)
Subject: RE: Opioid Crisis Grant - RHINO TA Request

Gentle reminder, We need more information to research this issue. Dan (ONC)

Daniel Chaput
202.260.0368 (Office)/202.746.9471 (Cell)
See my availability here.

From: Alvisurez, Jennifer (DOH)
Sent: Friday, December 14, 2018 4:45 PM
To: Chaput, Daniel (OS/ONC)
Cc: Daniel, James B. (HHS/CTO); Abbey, Rachel (OS/OSCP); Tandon, Sanjeev (CDC/DDPHSS/CSELS/OD); Close, Natasha (DOH); Wickersham, Kevin P (DOH); Deutsch, Sarah L (DOH); Meade, Rachel L (DOH)
Subject: RE: Opioid Crisis Grant - RHINO TA Request

Good afternoon Daniel,

I've included Natasha and Kevin in this email, they will be able to provide details.

Thanks,

Jennifer Alvisurez, MPH
Opioid Overdose Prevention Project Manager
Injury and Violence Prevention
Prevention and Community Health
Washington State Department of Health
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<https://twitter.com/wadepthealth?lang=en>
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<https://www.instagram.com/wadepthealth/>
<https://www.youtube.com/channel/UCTSCpezTD0TjiiAOuJY7f5w/doh>
<https://medium.com/@WADeptHealth>

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From: Chaput, Daniel (OS/ONC)
Sent: Friday, December 14, 2018 12:36 PM
To: Alvisurez, Jennifer (DOH)
Cc: Daniel, James B. (HHS/CTO); Abbey, Rachel (OS/OSCP); Tandon, Sanjeev (CDC/DDPHSS/CSELS/OD)
Subject: FW: Opioid Crisis Grant - RHINO TA Request

Jennifer,

Your email to CDC has landed on my desk. Can you provide details on the difficulties? I'd like to make sure we have the right people on the call when we meet.

Thanks,

Dan

Daniel Chaput
202.260.0368 (Office)/202.746.9471 (Cell)
See my availability here.

From: Alvisurez, Jennifer (DOH)
Sent: Tuesday, November 27, 2018 4:45 PM
To: Zhang, Kun (CDC/DDNID/NCIPC/DUIP)

Cc: Close, Natasha (DOH); Wickersham, Kevin P (DOH); Deutsch, Sarah L (DOH); Meade, Rachel L (DOH)
Subject: RE: Opioid Crisis Grant - RHINO TA Request

Hi Kun,

DOH has two request for TA under for projects under Domain 3 of NCIPC. The first item also falls under Domain 2 of NCHHSTP.

1. To support the development of geospatial visualizations for opioid overdose and risk factor data, we request training in ArcGIS and geospatial visualizations for our staff.
2. Several EHR vendors are having difficulty sending data for syndromic surveillance, limiting the representativeness of our syndromic surveillance data. We request that CDC work with the Office of the National Coordinator for Health Information Technology (HHS) to provide assistance to these vendors and ensure their capability to provide data. Vendors of concern include but are not limited to Athena Health, AllScripts, and eClinicalWorks.

Please let me know if you have any questions or concerns,

Thank you,

Jennifer Alvisurez, MPH
Opioid Overdose Prevention Project Manager
Injury and Violence Prevention
Prevention and Community Health
Washington State Department of Health
Jennifer.Alvisurez@doh.wa.gov
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<image003.png><image004.png><image005.png><image006.png><image007.png>

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From: Close, Natasha (DOH)
Sent: 1/17/2019 3:35:00 PM
To: English, Roseanne (CDC/DDPHSS/CSELS/DHIS)
Cc:
Subject: RE: TC Forum topics posted


attachments\7216995E03A64B02_image003.jpg


attachments\ABE31B85476C4173_image001.jpg


attachments\46DB183F77454D19_image002.jpg

Haha, great!

From: English, Roseanne (CDC/DDPHSS/CSELS/DHIS) [mailto:rxe1@cdc.gov]
Sent: Thursday, January 17, 2019 3:01 PM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Subject: RE: TC Forum topics posted

Got it. I just subscribed to the "additional query fields" and "uninformative chief complaint".

I have this down now!

:-)

Roseanne

Roseanne English

Analytic Data Management Lead
Surveillance and Data Science Team
Division of Health Informatics and Surveillance
Center for Surveillance, Epidemiology, and Laboratory Services
CDC Office of Public Health Scientific Services
1600 Clifton Road, Mail Stop: E-97, Atlanta, GA 30333
Email: rxe1@cdc.gov | Phone 404-498-2468 | Mobile: 404-580-4055

From: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Sent: Thursday, January 17, 2019 5:54 PM
To: English, Roseanne (CDC/DDPHSS/CSELS/DHIS) <rxe1@cdc.gov>
Subject: RE: TC Forum topics posted

Excellent. Yes, it's not intuitive. Just remember, that means you will see any new posts to those threads, but no resulting chatter within (not that there is much).

From: English, Roseanne (CDC/DDPHSS/CSELS/DHIS) [mailto:rxe1@cdc.gov]
Sent: Thursday, January 17, 2019 2:52 PM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Subject: RE: TC Forum topics posted

Thank you again. I think I know what was wrong.

I thought the "Green check box" suggested I was already subscribed. But I was not. You have to click on it and then it turns to a red X with "unsubscribe" as an option. I have gone ahead and subscribed for General and Technical Issues.

So I think I should start seeing emails.

Thank you so much!!

Roseanne

Roseanne English

Analytic Data Management Lead
Surveillance and Data Science Team
Division of Health Informatics and Surveillance
Center for Surveillance, Epidemiology, and Laboratory Services
CDC Office of Public Health Scientific Services
1600 Clifton Road, Mail Stop: E-97, Atlanta, GA 30333
Email: rxe1@cdc.gov | Phone 404-498-2468 | Mobile: 404-580-4055

From: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Sent: Wednesday, January 16, 2019 2:53 PM
To: English, Roseanne (CDC/DDPHSS/CSELS/DHIS) <rxe1@cdc.gov>
Subject: RE: TC Forum topics posted

See if this helps: https://vimeo.com/album/5083819/video/262846169

When you're in a forum, click on a forum thread.

On this page, you can subscribe to instant updates or a digest of new *topics* posted in this thread. You will ONLY see if someone posts a new topic posted by doing this.

If you want to see all postings under a topic (e.g., replies to topic), you will have to click on the topic of interest and subscribe to it.

Unfortunately there is no way to tell the website you want to know about all activity on a specific forum…you have to subscribe to all threads (to get notices when a new topic is posted) AND to each topic. PAINFUL!

From: English, Roseanne (CDC/DDPHSS/CSELS/DHIS) [mailto:rxe1@cdc.gov]
Sent: Tuesday, January 15, 2019 12:56 PM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Subject: RE: TC Forum topics posted

Thanks. I feel like an idiot but I can't figure out how to verify I am subscribed. Do you know? I never get any emails when posts are made to the DQ Committee forum so I must be doing something wrong!

Roseanne

Roseanne English

Analytic Data Management Lead
Surveillance and Data Science Team
Division of Health Informatics and Surveillance
Center for Surveillance, Epidemiology, and Laboratory Services
CDC Office of Public Health Scientific Services
1600 Clifton Road, Mail Stop: E-97, Atlanta, GA 30333
Email: rxe1@cdc.gov | Phone 404-498-2468 | Mobile: 404-580-4055

From: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Sent: Tuesday, January 15, 2019 11:02 AM
To: Hoferka, Stacey (CDC illinois.gov) <stacey.hoferka@illinois.gov>; DAVID.SWENSON@dhhs.nh.gov; Daniel.Bedford@dhs.wisconsin.gov; Wiedeman, Caleb (CDC tn.gov) <caleb.wiedeman@tn.gov>; Coletta, Michael A. (CDC/DDPHSS/CSELS/DHIS) <mac0@cdc.gov>; English, Roseanne (CDC/DDPHSS/CSELS/DHIS) <rxe1@cdc.gov>; Brown, Lindsay R. (CDC/DDPHSS/CSELS/DHIS) (CTR) <imb2@cdc.gov>; Powell, Ariel (CDC/DDPHSS/CSELS/DHIS) (CTR) <kyx6@cdc.gov>; Mishra, Kristina (CDC/DDPHSS/CSELS/DHIS) (CTR) <xyx7@cdc.gov>; ctong@syndromic.org
Subject: TC Forum topics posted

Just wanted to let you all know I was finally able to post updates to the TC forum about our two "issues" we discussed at the meeting. If you have, subscribe to the thread to see any comments. I'll try to send a message to the group letting them know and provide links to the postings. Cat - when you think the slides/recording will be posted? I refer to them in my posts. Thanks!

Natasha Close, MPH
Suveillance Epidemiologist
Division of Disease Control and Health Statistics
Washington State Department of Health
natasha.close@doh.wa.gov
206-430-0617 | www.doh.wa.gov
<https://twitter.com/wadepthealth?lang=en>
<https://www.facebook.com/WADeptHealth/>
<https://www.instagram.com/wadepthealth/>
<https://www.youtube.com/channel/UCTSCpezTD0TjiiAOuJY7f5w/doh>
<https://medium.com/@WADeptHealth>

From: Baumgart, Jim (GOV)
Sent: 1/21/2019 4:30:42 PM
To: Gupta, Rashi (GOV),Forrester, Sydney (GOV),Baumgart, Jim (GOV),GOV Fa Conf Room,Birch, Sue (HCA),MacEwan, Pam (HBE),Strange, Cheryl (DSHS/SEC),Eliason, Mark R. (DSHS/PER),Pannkuk, Richard (OFM),Williams, Robyn (OFM),Andersen, Bryce (OFM),Clintsman, Don (DSHS/SEC),Hallum, Sonja (GOV),O'Neill, Shawn (HCA),Altman, Joan (HBE),Nichols, Devon (OFM),Wiesman, John (DOH),Cooper, Kelly (DOH),Black, Ryan (DOH),Johnston, Kari (DCYF),Shirk, Drew (GOV),Adams, Angie (GOV),Ordway, Frank (DCYF),Hunter, Ross (DCYF),Hallum, Sonja (GOV),Altman, Joan (HBE),Audette, Heidi (DVA),Alvarado-Ramos, Alfie (DVA),Vasavada, Jasmine (COM),Robins, Connie (COM),Postman, David (GOV),Stamey, Gwen (OFM)
Cc:
Subject: Health and Human Services Sub-Cabinet Mtg - 22 Jan 19 @ 8 am

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attachments\93C93BBB3E2F4623_image004.png
attachments\75D6452BA425427D_image005.png
attachments\EC5161C6DEA14A4B_image002.png
attachments\FE7FABCFCC224B94_image001.png
attachments\21BEA826E62D400A_image003.png
attachments\AF6DDCA57BCE4B34_Agenda week #2 - Health and Human_PRDTOOL_NAMETOOLONG.docx

Agenda and bill list for tomorrow’s meeting.

JIM BAUMGART
Sr. Policy Advisor | Office of Governor Jay Inslee
Policy Office | Desk: 360.902.0559 | Cell: 360.480.9782
www.governor.wa.gov | Jim.Baumgart@gov.wa.gov
<https://www.facebook.com/WaStateGov> <https://twitter.com/GovInslee>
<https://www.flickr.com/photos/govinslee/sets>
<https://www.instagram.com/govinslee/> <https://medium.com/wagovernor>
<https://public.govdelivery.com/accounts/WAGOV/subscriber/new>

From: Baumgartner, Chris J (DOH)
Sent: 1/16/2019 1:03:00 PM
To: Meaningful Use (CDC)
Subject: RE: AIRA Comments on Reducing Provider Burden


attachments\A58FE8B0A4504143_image002.png


attachments\7F5EB3A26C564B95_image003.png

WA DOH is working on a set of comments that we will send out…

FYI

Chris Baumgartner
Senior Data Exchange Manager
Office of the State Health Officer
Washington State Department of Health
chris.baumgartner@doh.wa.gov
206-418-5530 | www.doh.wa.gov
<https://www.doh.wa.gov/Newsroom/SocialMedia>

From: Promoting Interoperability TaskForce [mailto:CDC-PH-INTEROPERABILITYTASKFORCE@LISTSERV.CDC.GOV] On Behalf Of Meaningful Use (CDC)
Sent: Wednesday, January 16, 2019 12:49 PM
To: CDC-PH-INTEROPERABILITYTASKFORCE@LISTSERV.CDC.GOV
Subject: AIRA Comments on Reducing Provider Burden
Importance: High

Greeting Task Force Members,

Thank so much Mary Beth for sharing your comments with the task force. We hope that the attachments can assist with creating comments on behalf of the task force.

Kindly note that we would like to request participation and comments from task members on the proposed strategy documentation. Steve and Mary Beth discussed a few additional comments that could be submitted by the task force.

Thank you all for your continued participation.

CDC/CSELS EHR Meaningful Use Team

Sanjeev Tandon MBBS, MD, MS
Lead-CDC Public Health & Promoting Interoperability Programs (formerly, known as Electronic Health Records Meaningful Use)
Office of the Director (OD)
Center for Surveillance, Epidemiology and Laboratory Services (CSELS)
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS E-94, Atlanta, GA 30333

Nina L. Mitchell BS, MS Heath Informatics
CDC/CSELS Public Health & Promoting Interoperability Programs (formerly, known as EHR Meaningful Use) Team
Chenega Corporation-Expert Consultant
Center for Surveillance, Epidemiology and Laboratory Services (CSELS)
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS E-94, Atlanta, GA 30333

To submit questions or request technical assistance for Public Health issues related to the Electronic Health Record (EHR) Meaningful Use Incentive Programs please contact us at:meaningfuluse@cdc.gov

---

From: Loschen, Wayne A.
Sent: 1/18/2019 10:47:25 AM
To: Close, Natasha (DOH),Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR)
Subject: RE: All Traffic Related v2 CCDD Category

Correct. It is running now.

I don't know if it will finish by Monday (we added 5 new categories), but it will be running all weekend for sure.

Wayne

Wayne Loschen
Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

From: Close, Natasha (DOH) <Natasha.Close@doh.wa.gov>
Sent: Friday, January 18, 2019 1:45 PM
To: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

I see you've put in the definition and am patiently waiting to use it as I assume the tables are building. Should I expect this process to complete by Monday?

Thanks!
natasha

From: Close, Natasha (DOH)
Sent: Thursday, January 17, 2019 11:32 AM
To: 'Loschen, Wayne A.' <Wayne.Loschen@jhuapl.edu>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Yay! So excited!!!!! Thanks!

Natasha

From: Loschen, Wayne A. [mailto:Wayne.Loschen@jhuapl.edu]
Sent: Thursday, January 17, 2019 11:27 AM
To: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Got it – thanks.

Wayne

Wayne Loschen
Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

From: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Sent: Thursday, January 17, 2019 2:05 PM
To: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>
Cc: Close, Natasha (CDC doh.wa.gov) <natasha.close@doh.wa.gov>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: All Traffic Related v2 CCDD Category

Wayne,

Please find Natasha's All Traffic Related v2 in the attached document. Please let me know if you have any questions about it.

Thank you!
Zach

ZACHARY STEIN, MPH
Syndromic Surveillance Analyst
ICF Contractor, BioSense Platform
Center for Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention (CDC)
316.371.3945
oru8@cdc.gov

From: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS)
Sent: 1/18/2019 10:49:12 AM
To: Loschen, Wayne (CDC jhuapl.edu),Close, Natasha (DOH),Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR)
Cc:
Subject: RE: All Traffic Related v2 CCDD Category

Yeah, and remember that Monday is a holiday, at least for us, but if Wayne is working and it's done perhaps he'll kick off the last step to re-build the cubes? After that it will be ready to use.

Aaron

From: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>
Sent: Friday, January 18, 2019 1:47 PM
To: Close, Natasha (CDC doh.wa.gov) <natasha.close@doh.wa.gov>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

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Wayne Loschen
Johns Hopkins University
Applied Physics Laboratory
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Laurel, MD 20723-6099
Phone: 443.778.7504

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Sent: Friday, January 18, 2019 1:45 PM
To: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

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From: Close, Natasha (DOH)
Sent: Thursday, January 17, 2019 11:32 AM
To: 'Loschen, Wayne A.' <Wayne.Loschen@jhuapl.edu>; Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

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Natasha

From: Loschen, Wayne A. [mailto:Wayne.Loschen@jhuapl.edu]
Sent: Thursday, January 17, 2019 11:27 AM
To: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
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Got it – thanks.

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Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

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Subject: All Traffic Related v2 CCDD Category

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Thank you!
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ZACHARY STEIN, MPH
Syndromic Surveillance Analyst
ICF Contractor, BioSense Platform
Center for Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention (CDC)
316.371.3945
oru8@cdc.gov

_____
From: Close, Natasha (DOH)
Sent: 1/17/2019 12:07:00 PM
To: Loschen, Wayne A.,Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR)
Subject: RE: All Traffic Related v2 CCDD Category

Hoping Zach knows what this means…I never submitted SQL before…

Natasha

From: Loschen, Wayne A. [mailto:Wayne.Loschen@jhuapl.edu]
Sent: Thursday, January 17, 2019 12:03 PM
To: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Cc: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Also – Zach,

The file is missing the SQL part.

Wayne

Wayne Loschen
Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

From: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Sent: Thursday, January 17, 2019 2:05 PM
To: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>
Cc: Close, Natasha (CDC doh.wa.gov) <natasha.close@doh.wa.gov>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: All Traffic Related v2 CCDD Category

Wayne,

Please find Natasha's All Traffic Related v2 in the attached document. Please let me know if you have any questions about it.

Thank you!
Zach

ZACHARY STEIN, MPH
Syndromic Surveillance Analyst
ICF Contractor, BioSense Platform
Center for Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention (CDC)
316.371.3945
oru8@cdc.gov

_____
From: Bryan, Zandt (DOH)
Sent: 1/16/2019 1:07:00 PM
To: Mobley, Kayla
Subject: RE: quick budget question - need response by or before 3pm

attachments\98A5A2278D3241D3_image005.jpg

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attachments\0C25381807514B9F_image001.jpg

attachments\FB526B63891048CA_image007.jpg

attachments\B2EE7E085DBA4C27_image003.jpg

Hi Kayla: Thanks for helping us. To answer your questions:

1. Upcoming Jan-Jun 2019 cycle is fine
a. Net FTE total
2. You are correct that it's all tasks except SSP.

Thanks –
z.

From: Mobley, Kayla [mailto:Kayla.Mobley@clark.wa.gov]
Sent: Wednesday, January 16, 2019 12:53 PM
To: Bryan, Zandt (DOH)
Cc: Nguyen, Dana
Subject: RE: quick budget question - need response by or before 3pm

Hey there, Zandt:

I'm the math-y type person here in Public Health, and I'm trying to help Dana get you the answers you need. I have a couple of questions:

1. Are you looking for total FTE funded by your portion of the grant the past cycle, or the upcoming Jan-Jun 2019 cycle?
a. Do you need the FTE total by employee, or just a net FTE total?
2. Are your portions described in the SOW as specific tasks? I'm assuming it's all tasks except SSP, but want to make sure.
a. Previous cycle tasks 2018:
TASK: PREV-1a State HIV Prev TASK: PREV-1b AAPPS TASK: PREV-1c ADAP RebateTASK: SSP-1 State HIV Prev

b. Jan-Jun 2019 tasks:
TASK: SSP TASK: Clark County Mobile Syringe TASK: Safer Syringe Disposal TASK: HIV/STD Prev - State HIV Prevention TASK: HIV/STD Prev - HIV Prevention (Cat A) TASK: HIV Positive (+) Prevention Activities

Thank you!
Kayla
<https://www.clark.wa.gov/>

Kayla Mobley
Senior Financial Management Analyst
PUBLIC HEALTH

564.397.8235

<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>
<https://twitter.com/ClarkCoWA> <https://www.youtube.com/user/ClarkCoWa/>

From: Bryan, Zandt (DOH) [mailto:Zandt.Bryan@DOH.WA.GOV]
Sent: Wednesday, January 16, 2019 11:56 AM
To: Nguyen, Dana; Czapla, Monica
Cc: Miller, Katrina (DOH)
Subject: RE: quick budget question - need response by or before 3pm

Great question – I wasn't clear enough, as I was moving quickly and forgot to qualify that. Thank you.

I'm talking about non-SSP staff – DIS or surveillance or program manager.

From: Nguyen, Dana [mailto:Dana.Nguyen@clark.wa.gov]
Sent: Wednesday, January 16, 2019 11:52 AM
To: Bryan, Zandt (DOH); Czapla, Monica
Cc: Miller, Katrina (DOH)
Subject: RE: quick budget question - need response by or before 3pm

Zandt,
Would you be able to provide the specific items in the Scope of Work fall under your specific contract? I believe that you are referring to all HIV/STD line items, correct? And Sarah has all SSP items?

Dana C. Nguyen BSN, RN, CIC
Infection Control Practitioner, Program Coordinator II
COMMUNICABLE DISEASE
1601 E Fourth Plain Blvd, Bldg 17, 3rd FLoor
PO Box 9825 | Vancouver, WA 98666-8825
564.397.2000 ext 7272 (note: our office area code has changed)
360.524.1167 cell
564.397.8080 fax (note: our office area code has changed)
dana.nguyen@clark.wa.gov

<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>
<https://twitter.com/ClarkCoWA> <https://www.youtube.com/user/ClarkCoWa/>

From: Bryan, Zandt (DOH) [mailto:Zandt.Bryan@DOH.WA.GOV]
Sent: Wednesday, January 16, 2019 11:05 AM

To: Czapla, Monica; Nguyen, Dana
Cc: Miller, Katrina (DOH)
Subject: quick budget question - need response by or before 3pm
Importance: High

Good morning, Monica, Dana:

About how many FTE in your program would you say the funds in the DOH contract I manage with you currently support in your program?

Thanks for any rapid response you can provide.
-z.

Zandt Bryan (pronouns: he/him)
Infectious Disease Field Services Coordinator
Washington Department of Health
PO Box 47840
Olympia, WA 98504
Zandt.Bryan@doh.wa.gov
T: (360) 890-5816
F: (360) 236-3470

Public health: always working for a safer and healthier Washington.

This e-mail and related attachments and any response may be subject to public disclosure under state law.

From: Allen, Sheanne (DOH)
Sent: 1/17/2019 6:00:25 PM
To: Brianna.dannen@clark.wa.gov
Cc:
Subject: Nurse line

Hi Brianna-
Email is the preferred method for providers to reach the OICP nurses, however the general 800 number is on the bottom of the webpage. Our Admin staff can transfer the calls to the nurses if they come in on that line.

https://www.doh.wa.gov/YouandYourFamily/Immunization/ContactUs

Please let providers know they can email the WAChildhoodVaccines@doh.wa.gov email and we can forward their questions to the nurses as well. I want to remove as many barriers as possible for the providers.

Please let me know if you need anything else, we are here to support! Again, I am in Atlanta next week but feel free to call my cell anytime. Also, I can share information about the MCM Strike Team

SheAnne

SheAnne Allen, MPH, MCHES
Vaccine Management Section Manager
Office of Immunizations and Child Profile
Washington State Department of Health
PO Box 47843, Olympia, WA 98504
Email: sheanne.allen@doh.wa.gov
PH: 360-236-3578 | Fax: 360-236-3590
www.doh.wa.gov/youandyourfamily/immunization

From: Mary McHale
Sent: 1/21/2019 4:08:15 PM
To: Alexa Silver
Subject: Re: Tobacco 21 - Next Steps

Great work, everyone!

Mary McHale
Washington Government Relations Director
206.674.4187 | m: 610.417.4746 | f: 206.285.5108

American Cancer Society Cancer Action Network, Inc.
555 11th Street NW Suite 300
Washington, DC 20004
fightcancer.org | 1.800.227.2345

Cancer prevention starts with healthy lifestyle choices.

Reduce your risk of cancer by eating healthy, staying active, not smoking, and following screening and vaccination guidelines.

From: Alexa Silver <alexa.r.silver@gmail.com>
Sent: Monday, January 21, 2019 4:03:38 PM
To: Mary McHale
Cc: Alma Gottlieb-McHale; Andrea Tull; Annie Tegen; Lauren Y Baba; Brittany Gregory; Brynn Brady; carrie dzpublicaffairs.com; Carrie Nyssen; chelsea@insightstrategicpartners.com; Kelly Cooper; David Foster; erin dzpublicaffairs.com; Alicia B Eyler; grace. henscheid; Julie Peterson; Kate White Tudor; Katie Kolan; Lindsay Hovind; Webb, Mike (ATG); Jason McGill; Jim Justin; Patty Seib; Amber Oar Ulvenes
Subject: Re: Tobacco 21 - Next Steps

SB 5057 passed out of Senate Health & Long-Term Care this afternoon. They adopted an amendment to petition Congress to raise the age to 21 at the federal level, as well.

Alexa

Alexa Silver
alexa.r.silver@gmail.com
360-951-4564

On Jan 18, 2019, at 11:20 AM, Mary McHale <mary.mchale@cancer.org> wrote:

Hi all - general consensus is the Senate HLTC hearing on SB 5057 this morning went well. It was a bit broken up and our panels were scattered throughout the hearing. We also did not have as much time as the House hearing. But overall, testimony was great and we're happy with how things went.

From our 10:30 check in call, here are the updates and next steps:

* We keep hearing that both chambers want to run this quickly.
* Cleveland said she'd try to exec 5057 out on Monday depending on any amendments that may come up. We have not heard of any pending amendments.
* Cody has had initial conversations with Ormsby about scheduling 1074 in approps the week of 1/28

Electeds with whom to check in if you've got meetings coming up:
* Senate Rs, including Bailey, Rivers & O'Ban - they are sponsors but we will need keep confirming their support

* Cody - just check in on next steps after it goes through her committee

IMPORTANT: I am maintaining a vote tracker. As you meet with electeds and confirm their position, let me know either via text or email & I will update the document. My cell is listed below.

The vote tracker can be viewed here. If you have any edits, just let me know.

Mary McHale
Gender Pronouns: they/them
Washington Government Relations Director
206.674.4187 | m: 610.417.4746 | f: 206.285.5108

American Cancer Society Cancer Action Network, Inc.
555 11th Street NW Suite 300
Washington, DC 20004
fightcancer.org | 1.800.227.2345

<https://www.fightcancer.org/>

disseminate this message or any part of it. If you have received this message in error, please notify the sender immediately.

_____
From: Close, Natasha (DOH)
Sent: 1/21/2019 9:13:38 AM
To: Loschen, Wayne A.
Subject: Re: All Traffic Related v2 CCDD Category

Thanks for the update. Sounds like it will or finish up today. Got some other stuff planned for today so I'll hope to make use of it tomorrow!

Natasha Close, MPH
Suveillance Epidemiologist
Division of Disease Control and Health Statistics
Washington State Department of Health
natasha.close@doh.wa.gov
206-430-0617 | www.doh.wa.gov
<https://twitter.com/wadepthealth?lang=en>
<https://www.facebook.com/WADeptHealth/>
<https://www.instagram.com/wadepthealth/>
<https://www.youtube.com/channel/UCTSCpezTD0TjiiAOuJY7f5w/doh>
<https://medium.com/@WADeptHealth>

On Jan 21, 2019, at 7:46 AM, Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu> wrote:

Just a status.

The All Traffic Related v2 is still running.

They are in 2017 and 2018 (web and detection db)

So – they're getting there.

Wayne

Wayne Loschen
Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099
Phone: 443.778.7504

From: Loschen, Wayne A.
Sent: Friday, January 18, 2019 1:58 PM
To: 'Close, Natasha (DOH)' <Natasha.Close@doh.wa.gov>; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Cc: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

So,

Of the 5 CCDD Categories, I am updating them in this order:

Asthma
Food Poisoning

Measles
Pneumonia
Traffic

It is currently finished the first 2, and is on Measles – Dec 1999 (it starts from 1900 and works its way to today)

It's tough to project though, because the Pneumonia and Traffic ones will be slower (they're more complex)

Wayne

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Division of Disease Control and Health Statistics
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I don't know if it will finish by Monday (we added 5 new categories), but it will be running all weekend for sure.

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Thanks!
natasha

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Cc: Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS) <lyv8@cdc.gov>
Subject: RE: All Traffic Related v2 CCDD Category

Yay! So excited!!!!! Thanks!

Natasha

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Subject: RE: All Traffic Related v2 CCDD Category

Got it – thanks.

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Johns Hopkins University
Applied Physics Laboratory
11100 Johns Hopkins Road
Laurel, MD 20723-6099

Phone: 443.778.7504

From: Stein, Zachary (CDC/DDPHSS/CSELS/DHIS) (CTR) <oru8@cdc.gov>
Sent: Thursday, January 17, 2019 2:05 PM
To: Loschen, Wayne A. <Wayne.Loschen@jhuapl.edu>
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Subject: All Traffic Related v2 CCDD Category

Wayne,

Please find Natasha's All Traffic Related v2 in the attached document. Please let me know if you have any questions about it.

Thank you!
Zach

ZACHARY STEIN, MPH
Syndromic Surveillance Analyst
ICF Contractor, BioSense Platform
Center for Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention (CDC)
316.371.3945
oru8@cdc.gov

_____
From: Mobley, Kayla
Sent: 1/16/2019 4:25:05 PM
To: Bryan, Zandt (DOH)
Subject: RE: quick budget question - need response by or before 3pm


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attachments\2CEE52361C2D44E2_image008.jpg


attachments\613888CB94314600_image003.jpg


attachments\CDAC7CB4FB624DA8_image005.jpg


attachments\FD0874F256B94AFC_image001.jpg

Sorry Zandt; just realized I calculated based on a full calendar year, not 6 months. Should be about 1.6 FTE.

From: Mobley, Kayla
Sent: Wednesday, January 16, 2019 4:21 PM
To: 'Bryan, Zandt (DOH)'
Cc: Nguyen, Dana
Subject: RE: quick budget question - need response by or before 3pm

Zandt,

I would estimate that the grants (excluding SSP) support approximately .8 FTE

Thank you,
Kayla

From: Bryan, Zandt (DOH) [mailto:Zandt.Bryan@DOH.WA.GOV]
Sent: Wednesday, January 16, 2019 1:08 PM
To: Mobley, Kayla
Cc: Nguyen, Dana
Subject: RE: quick budget question - need response by or before 3pm

Hi Kayla: Thanks for helping us. To answer your questions:

1. Upcoming Jan-Jun 2019 cycle is fine
a. Net FTE total
2. You are correct that it's all tasks except SSP.

Thanks –
z.

From: Mobley, Kayla [mailto:Kayla.Mobley@clark.wa.gov]
Sent: Wednesday, January 16, 2019 12:53 PM
To: Bryan, Zandt (DOH)

Cc: Nguyen, Dana
Subject: RE: quick budget question - need response by or before 3pm

Hey there, Zandt:

I'm the math-y type person here in Public Health, and I'm trying to help Dana get you the answers you need. I have a couple of questions:

1. Are you looking for total FTE funded by your portion of the grant the past cycle, or the upcoming Jan-Jun 2019 cycle?
a. Do you need the FTE total by employee, or just a net FTE total?
2. Are your portions described in the SOW as specific tasks? I'm assuming it's all tasks except SSP, but want to make sure.
a. Previous cycle tasks 2018:
TASK: PREV-1a State HIV Prev TASK: PREV-1b AAPPS TASK: PREV-1c ADAP RebateTASK: SSP-1 State HIV Prev

b. Jan-Jun 2019 tasks:
TASK: SSP TASK: Clark County Mobile Syringe TASK: Safer Syringe Disposal TASK: HIV/STD Prev - State HIV Prevention TASK: HIV/STD Prev - HIV Prevention (Cat A) TASK: HIV Positive (+) Prevention Activities

Thank you!
Kayla
<https://www.clark.wa.gov/>

Kayla Mobley
Senior Financial Management Analyst
PUBLIC HEALTH

564.397.8235

<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>
<https://twitter.com/ClarkCoWA> <https://www.youtube.com/user/ClarkCoWa/>

From: Bryan, Zandt (DOH) [mailto:Zandt.Bryan@DOH.WA.GOV]
Sent: Wednesday, January 16, 2019 11:56 AM
To: Nguyen, Dana; Czapla, Monica
Cc: Miller, Katrina (DOH)
Subject: RE: quick budget question - need response by or before 3pm

Great question – I wasn't clear enough, as I was moving quickly and forgot to qualify that. Thank you.

I'm talking about non-SSP staff – DIS or surveillance or program manager.

From: Nguyen, Dana [mailto:Dana.Nguyen@clark.wa.gov]
Sent: Wednesday, January 16, 2019 11:52 AM
To: Bryan, Zandt (DOH); Czapla, Monica
Cc: Miller, Katrina (DOH)
Subject: RE: quick budget question - need response by or before 3pm

Zandt,
Would you be able to provide the specific items in the Scope of Work fall under your specific contract? I believe that you are referring to all HIV/STD line items, correct? And Sarah has all SSP items?

Dana C. Nguyen BSN, RN, CIC
Infection Control Practitioner, Program Coordinator II
COMMUNICABLE DISEASE
1601 E Fourth Plain Blvd, Bldg 17, 3rd FLoor
PO Box 9825 | Vancouver, WA 98666-8825
564.397.2000 ext 7272 (note: our office area code has changed)
360.524.1167 cell
564.397.8080 fax (note: our office area code has changed)
dana.nguyen@clark.wa.gov

<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>
<https://twitter.com/ClarkCoWA> <https://www.youtube.com/user/ClarkCoWa/>

From: Bryan, Zandt (DOH) [mailto:Zandt.Bryan@DOH.WA.GOV]
Sent: Wednesday, January 16, 2019 11:05 AM
To: Czapla, Monica; Nguyen, Dana
Cc: Miller, Katrina (DOH)
Subject: quick budget question - need response by or before 3pm
Importance: High

Good morning, Monica, Dana:

About how many FTE in your program would you say the funds in the DOH contract I manage with you currently support in your program?

Thanks for any rapid response you can provide.
-z.

Zandt Bryan (pronouns: he/him)
Infectious Disease Field Services Coordinator
Washington Department of Health
PO Box 47840
Olympia, WA 98504
Zandt.Bryan@doh.wa.gov
T: (360) 890-5816
F: (360) 236-3470

Public health: always working for a safer and healthier Washington.

This e-mail and related attachments and any response may be subject to public disclosure under state law.
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From: Close, Natasha (DOH)
Sent: 1/16/2019 11:52:00 AM
To: English, Roseanne (CDC/DDPHSS/CSELS/DHIS)
Cc:
Subject: RE: TC Forum topics posted

attachments\452826A3D94F4EAA_image006.jpg

attachments\D032B53FA4354664_image001.jpg

attachments\8BCEC627C396445F_image002.jpg

See if this helps: https://vimeo.com/album/5083819/video/262846169

When you're in a forum, click on a forum thread.

On this page, you can subscribe to instant updates or a digest of new *topics* posted in this thread. You will ONLY see if someone posts a new topic posted by doing this.

If you want to see all postings under a topic (e.g., replies to topic), you will have to click on the topic of interest and subscribe to it.

Unfortunately there is no way to tell the website you want to know about all activity on a specific forum…you have to subscribe to all threads (to get notices when a new topic is posted) AND to each topic. PAINFUL!

From: English, Roseanne (CDC/DDPHSS/CSELS/DHIS) [mailto:rxe1@cdc.gov]
Sent: Tuesday, January 15, 2019 12:56 PM
To: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Subject: RE: TC Forum topics posted

Thanks. I feel like an idiot but I can't figure out how to verify I am subscribed. Do you know? I never get any emails when posts are made to the DQ Committee forum so I must be doing something wrong!

Roseanne

Roseanne English

Analytic Data Management Lead
Surveillance and Data Science Team
Division of Health Informatics and Surveillance
Center for Surveillance, Epidemiology, and Laboratory Services
CDC Office of Public Health Scientific Services
1600 Clifton Road, Mail Stop: E-97, Atlanta, GA 30333
Email: rxe1@cdc.gov | Phone 404-498-2468 | Mobile: 404-580-4055

From: Close, Natasha (DOH) <Natasha.Close@DOH.WA.GOV>
Sent: Tuesday, January 15, 2019 11:02 AM

To: Hoferka, Stacey (CDC illinois.gov) <stacey.hoferka@illinois.gov>; DAVID.SWENSON@dhhs.nh.gov; Daniel.Bedford@dhs.wisconsin.gov; Wiedeman, Caleb (CDC tn.gov) <caleb.wiedeman@tn.gov>; Coletta, Michael A. (CDC/DDPHSS/CSELS/DHIS) <mac0@cdc.gov>; English, Roseanne (CDC/DDPHSS/CSELS/DHIS) <rxe1@cdc.gov>; Brown, Lindsay R. (CDC/DDPHSS/CSELS/DHIS) (CTR) <imb2@cdc.gov>; Powell, Ariel (CDC/DDPHSS/CSELS/DHIS) (CTR) <kyx6@cdc.gov>; Mishra, Kristina (CDC/DDPHSS/CSELS/DHIS) (CTR) <xyx7@cdc.gov>; ctong@syndromic.org
Subject: TC Forum topics posted

Just wanted to let you all know I was finally able to post updates to the TC forum about our two "issues" we discussed at the meeting. If you have, subscribe to the thread to see any comments. I'll try to send a message to the group letting them know and provide links to the postings. Cat - when you think the slides/recording will be posted? I refer to them in my posts. Thanks!

Natasha Close, MPH
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Centers for Disease Control and Prevention (CDC)
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oru8@cdc.gov

BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: Z-0126.7/19 7th draft

ATTY/TYPIST: KS:amh

BRIEF DESCRIPTION: Concerning foundational public health services.

AN ACT Relating to foundational public health services; amending RCW 43.70.512; adding a new section to chapter 43.70 RCW; and repealing RCW 43.70.514, 43.70.516, 43.70.520, 43.70.522, and 43.70.580.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 43.70.512 and 2007 c 259 s 60 are each amended to read as follows:

(1) Protecting the public's health across the state is a fundamental responsibility of the state((~~. With any new state funding of the public health system as appropriated for the purposes of sections 60 through 65 of this act, the state expects that measurable benefits will be realized to the health of the residents of Washington. A transparent process that shows the impact of increased public health spending on performance measures related to the health outcomes in subsection (2) of this section is of great value to the state and its residents. In addition, a well-funded public health system is expected to become a more integral part of the state's emergency preparedness system.~~

~~(2) Subject to the availability of amounts appropriated for the purposes of sections 60 through 65 of this act, distributions to local health jurisdictions shall deliver the following outcomes:~~

~~(a) Create a disease response system capable of responding at all times;~~

~~(b) Stop the increase in, and reduce, sexually transmitted disease rates;~~

~~(c) Reduce vaccine preventable diseases;~~

~~(d) Build capacity to quickly contain disease outbreaks;~~

~~(e) Decrease childhood and adult obesity and types I and II diabetes rates, and resulting kidney failure and dialysis;~~

~~(f) Increase childhood immunization rates;~~

~~(g) Improve birth outcomes and decrease child abuse;~~

~~(h) Reduce animal-to-human disease rates; and~~

~~(i) Monitor and protect drinking water across jurisdictional boundaries.~~

~~(3) Benchmarks for these outcomes shall be drawn from the national healthy people 2010 goals, other reliable data sets, and any subsequent national goals~~)) and is accomplished through the governmental public health system. This system is comprised of the state department of health, state board of health, local health jurisdictions, sovereign tribal nations, and Indian health programs.

(2)(a) The legislature intends to define a limited statewide set of core public health services, called foundational public health services, which the governmental public health system is responsible for providing in a consistent and uniform way in every community in Washington. These services are comprised of foundational programs and cross-cutting capabilities.

(b) These governmental public health services should be delivered in ways that maximize the efficiency and effectiveness of the overall system, make best use of the public health workforce and evolving technology, and address health equity.

(c) Funding for the governmental public health system must be restructured to support foundational public health services. In restructuring, there must be efforts to both reinforce current governmental public health system capacity and implement service delivery models allowing for system stabilization and transformation.

NEW SECTION. **Sec. 2.** A new section is added to chapter 43.70 RCW to read as follows:

(1) With any state funding of foundational public health services, the state expects that measurable benefits will be realized to the health of communities in Washington as a result of the

improved capacity of the governmental public health system. Close coordination and sharing of services are integral to increasing system capacity.

(2)(a) Funding for foundational public health services shall be appropriated to the office of financial management. The office of financial management may only allocate funding to the department if the department, after consultation with federally recognized Indian tribes, a state association representing local health jurisdictions, and the state board of health, jointly certify to the office of financial management that they are in agreement on the distribution and uses of state foundational public health services funding across the public health system.

(b) If joint certification is provided, the department shall distribute foundational public health services funding according to the agreed-upon distribution and uses. If joint certification is not provided, appropriations for this purpose shall lapse.

(3) By October 1, 2020, the department, in consultation with local health jurisdictions, sovereign tribal nations, and the state board of health, shall report on:

(a) Service delivery models, and a plan for further implementation of successful models;

(b) Changes in capacity of the governmental public health system; and

(c) Progress made to improve health outcomes.

(4) For purposes of this section:

(a) "Foundational public health services" means a limited statewide set of defined public health services within the following areas:

(i) Control of communicable diseases and other notifiable conditions;

(ii) Chronic disease and injury prevention;

(iii) Environmental public health;

(iv) Maternal, child, and family health;

(v) Access to and linkage with medical, oral, and behavioral health services;

(vi) Vital records; and

(vii) Cross-cutting capabilities, including:

(A) Assessing the health of populations;

(B) Public health emergency planning;

(C) Communications;

(D) Policy development and support;

(E) Community partnership development; and

(F) Business competencies.

(b) "Governmental public health system" means the state department of health, state board of health, local health jurisdictions, sovereign tribal nations, and Indian health programs located within Washington.

(c) "Indian health programs" means tribally operated health programs, urban Indian health programs, tribal epidemiology centers, the American Indian health commission for Washington state, and the Northwest Portland area Indian health board.

(d) "Local health jurisdictions" means a public health agency organized under chapter 70.05, 70.08, or 70.46 RCW.

(e) "Service delivery models" means a systematic sharing of resources and function among state and local governmental public health entities, sovereign tribal nations, and Indian health programs to increase capacity and improve efficiency and effectiveness.

NEW SECTION. **Sec. 3.** The following acts or parts of acts are each repealed:

(1) RCW 43.70.514 (Public health—Definitions) and 2007 c 259 s 61;

(2) RCW 43.70.516 (Public health—Department's duties) and 2007 c 259 s 62;

(3) RCW 43.70.520 (Public health services improvement plan—Performance measures) and 2007 c 259 s 64 & 1993 c 492 s 467;

(4) RCW 43.70.522 (Public health performance measures—Assessing the use of funds—Secretary's duties) and 2007 c 259 s 65; and

(5) RCW 43.70.580 (Public health improvement plan—Funds—Performance-based contracts—Rules—Evaluation and report) and 1995 c 43 s 3.

--- END ---

Budget Spreadsheet - FPHS CD Subgroup Assignment from FPHS Steering Committee (1-18-2019)

FPHS CD PROPOSAL	Original Propopsal ($/biennium)	$40M Proposal ($/biennium)	% Reduction from Original Proposal	NOTES
PUBLIC HEALTH LABORATORY				
Micro & ELS Lab				
Foodborne Disease	498,353	498,353		
Water Bacteriology	249,176	0		
Radiation	284,081	0		
Radiation	192,708	0		
Emerging Diseases/Issues				
Hepatitis C	498,353	498,353		
Blood lead, PFAS, opioids	284,081	0		
TB Testing (DRSS)	249,176	249,176		
Quality Assurance/Training				
QA/Training	249,176	249,176		
QA/Training	260,220	0		
Data System Interoperability				
LIMS Data System Replacement	2,530,000	400,000		Match dollars for HCA IAPD Grant
Total	**5,295,324**	**1,895,058**	**64**	
WDRS SURVEILLANCE DATA SYSTEM				
Planning, Design, and Development				
Project Manager - Manages Project Design Work	355,382	0		
Development Supervisor	177,690	0		
SME Support to New Program Development, Work with SMEs	290,570	0		
Developers	649,499	0		
Business Analyst	324,749	0		
Contractor/Vendor Costs - Conduent	700,000	0		
Contractor Costs - Johns Hopkins University	120,000	0		
Match dollars for IAPD Grant	--	400,000		Match dollars for HCA IAPD Grant
Maintenance & Operation				
Supervisor/Lead	284,081	284,081		
Informatics/CD surveillance reporting	332,166	332,166		
Deduplication and data management	467,075	467,075		
Tester	297,059	297,059		
Business Analyst	324,749	324,749		
Developer	487,124	487,124		
Release Manager	177,690	177,690		
Contractor/Vendor Costs - Conduent	240,000	240,000		
Compliance & Reporting				
LHJ Engagement Specialist	290,570	0		
Data Quality Assurance	332,166	0		
Other Investments (LHJs)				
Statewide WDRS Advisory Board (0.1 FTE for 10 LHJs)	267,014	0		
Total	**6,117,584**	**3,009,944**	**51**	
IMMUNIZATION SUPPORT				
DOH Investments				
Immunization Epi/Assessment Support to LHJs	782,500	342,000		
Improve Immunization Data Quality	867,500	420,000		Match dollars for HCA IAPD Grant
Total	**1,650,000**	**762,000**	**54**	
GENERAL COMMUNICABLE DISEASE PROPOSAL				
DOH Investments				
Emergency Response and Surge Capacity During Outbreaks	332,166	332,166		
Outbreak investigation and surveillance for Hep B	290,570	0		
Outbreak investigation and surveillance for Hep B	233,538	0		
Core Surveillance and Center of Excellence/LHJ Support, Reporting to CDC	664,331	332,166		Reduce by 1 FTE
SME in Refugee Health and Support to LHJs	407,416	407,416		
HAI - Conduct Infection Control Assessment and Response	355,382	355,382		
Hepatitis C - Conduct Epi Surveillance and Support	581,140	581,140		
Hepatitis C - Supervisor/Lead	284,081	284,081		
Hepatitis C - Technical Assistance, quality assurance for outbreaks/complicated cases	520,440	520,440		
Hepatitis C - Chronic HCV investigations	700,613	700,613		
Hepatitis C - Lab Reporting and Lab Follow Up	201,172	201,172		
Data System - Support assessment and Enhancement of CD Surveillance	332,166	0		
Data System - Supervisor	142,040	0		
Data System - Systems Coordinator	363,523	0		
LHJ Investments				

General Communicable Disease Support	8,010,420	8,010,420		
HAI Support	1,068,056	534,028		Reduce by 2 FTEs
Hepatitis C	4,005,210	4,005,210		
Total	**18,492,264**	**16,264,234**	**12**	
HIV, SYPHILIS, AND GONORRHEA SURVEILLANCE SYSTEM				
DOH Investments				
Disease Surveillance and Disease Investigations	585,495	292,748		Reduce by 1 FTE
Supervisor/Lead	284,081	284,081		
Mentors for Statewide DIS Network	520,440	260,220		Reduce by 1 FTE
Conduct Surveillance from Lab Reports and Provider Case Reports	581,140	290,570		Reduce by 1 FTE
LHJ Investments				
HIV/Gonorrhea/Syphilis Disease Intervention/Surveillance Support	6,675,350	6,675,350		
Total	**8,646,506**	**7,802,969**	**10**	
TUBERCULOSIS (TB) PREVENTION AND CONTROL				
DOH Investments				
Conduct Epi Profiles to identify high risk populations	332,166	332,166		
Informatics Focus	332,166	0		
Supervisor/Lead	284,081	284,081		
LTBI Work	260,220	0		
Support TB Elimination Efforts	201,172	0		
New WDRS Enhancement to upload all Class Bs	320,000	0		
Support for FQHCs to develop in Clinic LTBI Performance Measures	480,000	0		
Investments to LHJs				
Additional LHJ Resources for TB disease/case and contact investigation	910,000	910,000		
Treatment Costs to LHJs for a Complex Case	520,000	520,000		
LHJ Resources for Class B Evaluation & Treatment Support	900,000	900,000		
Electronic Directly Observed Therapy (eDOT) platform support for all LHJs	100,000	100,000		
Short-Course LTBI Medication Coverage Through Expanded 340B for LHJs/FQHCs	480,000	0		
Develop and Maintain a Statewide Advisory Board (0.1 FTE to 6 LHJs)	420,000	0		
Continue and Expand Demonstration Project	1,030,000	0		
Total	**6,569,805**	**3,046,247**	**54**	
REINFORCING CAPACITY TO LHJs	13,372,000	10,000,000		
Total	**13,372,000**	**10,000,000**	**25**	
GRAND TOTAL	**60,143,483**	**42,780,452**		

AIRA
AMERICAN IMMUNIZATION REGISTRY ASSOCIATION

January 4, 2019

Dr. Don Rucker
National Coordinator for Health Information Technology
US Department of Health and Human Services
330 C St. SW, Floor 7
Washington, DC 20201

DRAFT Comments RE: Strategy on Reducing Burden Relating to the Use of Health IT and EHRs, Request for Comments

Dear Dr. Rucker -

On behalf of the American Immunization Registry Association (AIRA) we are pleased to submit comments on the Office of the National Coordinator's (ONC's) **Strategy on Reducing Burden Relating to the Use of Health IT and EHRs.** As a member organization with more than 600 members representing 77 Public Health organizations, 12 businesses and sponsors, and 512 individuals from Immunization Information System (IIS) programs and partners, these comments represent a broad perspective on federal actions that affect immunization programs across the country, particularly as they relate to issues that impact the interoperability of immunization records.

AIRA members appreciate ONC's focus on reducing burden regarding the use of health IT; however, it is also critically important to recognize those areas where health IT brings value and lowers burden for providers and end users. IIS, or immunization registries, are available and highly utilized in nearly every state across the US. They support provider access to the most complete, timely and accurate immunization information available.

The broad availability of immunization data through real-time Electronic Health Record (EHR)-IIS query significantly lowers the burden (and cost) to providers in accessing immunization records and forecasts at the point of care. This functionality to query the IIS from within an EHR and receive back a consolidated record and forecast for immunizations due is currently available to providers in over three quarters of states across the country and is in the process of being developed in the remaining locations. This accelerated adoption of query functions across EHRs and IIS is due in large part to incentives provided through Meaningful Use (MU)/Promoting Interoperability (PI).

Incentive programs such as MU/PI and MACRA/MIPS have significantly increased reporting and use of immunization data between provider EHRs and IIS or registries. Providers have worked hard to prioritize capture and submission of immunization data, and have added IIS query into their workflow to support their clinical decisions. As a result of these incentive programs, not only do providers have access to more complete data and forecasts, but IIS now have more robust data in systems that support immunization activities across the health care continuum. These more complete and accurate longitudinal data are now accessible for an infinite number of programs and organizations, including Medicaid, Accountable Care Organizations (ACOs), health plans conducting HEDIS measurement, clinics and health systems providing clinical care and evaluating quality measures, and public health organizations committed to preventing vaccine preventable diseases.

Immunization providers rely on IIS to implement an increasingly complex vaccination schedule, as well as monitor vaccine safety, efficacy, and vaccine delivery. IIS play an essential role in creating a comprehensive consolidated immunization record, assisting with vaccine evaluation and forecasting, generating patient reminders, assessing vaccine uptake, providing schools and childcare providers access to consolidated records, assisting with vaccine ordering and inventory management, supporting outbreak investigation, calculating vaccine coverage estimates, and much more.

It is important to note that immunizations are acknowledged as one of the most effective and life-saving health interventions of modern medicine; CDC states that the vaccinations given to infants and young children in the past 20 years alone will prevent an estimated 322 million illnesses and save 732,000 lives just in the United States.[1] Similarly, an evidence-based systematic review demonstrated IIS capabilities and actions in increasing vaccination rates, contributing heavily to the overall goal of reducing vaccine-preventable disease.[2] IIS are increasingly well-populated, with childhood IIS participation increasing from 90% in 2013 to 95% in 2017, now reaching the Healthy People 2020 objective of ≥95% child IIS participation.[3] Similar growth in IIS population capture has been seen with adolescents and adults, where IIS store

[1] MMWR, 2014, accessed 5/28/2018: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6316a4.htm
[2] Journal of Public Health Management Practice, 2014, Accessed 5/28/18: https://www.thecommunityguide.org/sites/default/files/publications/vpd-jphpm-evrev-IIS.pdf
[3] MMWR, 2017, accessed 5/31/2018: https://www.cdc.gov/mmwr/volumes/66/wr/mm6643a4.htm

immunization data on 79% of 11-17 year olds and 51% of age 19 years and above of the population.[4]

In addition to the comments above, AIRA provides suggestions on the ONC report in our detailed comments presented on the following pages, organized by page number and section within the report. Please contact Mary Beth Kurilo, AIRA's Policy and Planning Director, with any questions: mbkurilo@immregistries.org.

AIRA greatly appreciates the opportunity to comment on this ONC report, and we look forward to continuing to collaborate to ensure high-value health IT interoperability with our many partners.

Sincerely,

Rebecca Coyle, MSEd, Executive Director

[4] CDC, 2017, IIS Annual Report Data (unpublished)

AIRA
AMERICAN IMMUNIZATION REGISTRY ASSOCIATION

Comments on the ONC Report: Strategy on Reducing Burden Relating to the Use of Health IT and EHRs

Page Number	Excerpt	Comment
Pg. 13	The primary burdens in this section relate to: a lack of automated, standards-based public health reporting requirements across federal programs; burden related to electronic prescribing of controlled substances (EPCS); and insufficient interoperability between state prescription drug monitoring programs (PDMPs) and EHRs.	AIRA, the IIS community, providers, and the EHR community have worked hard to standardize interoperability across our industries, and although this effort continues, we have improved and streamlined data exchange significantly. We welcome the opportunity to share our lessons learned about standardization with state prescription drug monitoring programs (PDMPs). We also want to emphasize that there are differences in public health reporting that are driven by very real differences in functions needed to protect the public's health.

Page Number	Excerpt	Comment
Pg. 13	Specifically, in the FY 2019 IPPS/LTCH PPS final rule and the CY 2019 Physician Fee Schedule final rule, CMS added two new measures to the Promoting Interoperability Program focused on EPCS that together support broader HHS efforts to increase the use of PDMPs.	While EPCS and PDMP are extremely important and worthwhile programs, it is critical we continue to emphasize and support the benefits from previous areas of focus and to maintain existing integrations with fundamental public health areas like EHR-IIS interoperability. We want to maintain the outstanding level of connectivity achieved from years of investment in immunization submission and query.
Pg. 42	Even within one public health jurisdiction, different transport requirements may be required for different public health options. For example, Simple Object Access Protocol (SOAP) web services may be required for immunization reporting while secure File Transfer Protocol (FTP) may be required for syndromic surveillance.	Although ideally all transport methods would be identical, the use cases with each public health program often drive each program's standards. For example, IIS-EHR bidirectional exchange requires real-time synchronous interoperability, which is best served with SOAP/Web Services. Syndromic data flows unidirectionally, so FTP is satisfactory. Business needs should not be overlooked in favor of uniformity.

Page Number	Excerpt	Comment
Pg. 42-43	Although much of the data collected for WIC pertains to social services and food products supplied to clients, there are numerous clinical data elements related to well child visits and immunizations that must be manually entered into the WIC system.	Many states have instituted electronic data exchange relationships between IIS and WIC; ideally, this allows WIC to query and import the most complete and accurate immunization records directly from their jurisdiction's IIS, lowering the manual entry burden and saving time for both WIC staff and recipients.
Pg. 61	**EHR Reporting:** **Recommendation 1:** Recognize industry-approved best practices for data mapping to improve data accuracy and reduce administrative and financial burdens associated with health IT reporting. **Recommendation 2:** Adopt additional data standards to makes access to data, extraction of data from health IT systems, integration of data across multiple health IT systems, and analysis of data easier and less costly for physicians and hospitals.	Having worked (and continuing to work) to integrate standards and best practices across the IIS community, AIRA fully supports the further integration of standards and best practices to increase the value and lower the burden of interoperability from the EHR perspective.

Page Number	Excerpt	Comment
Pg. 65	**Public Health Reporting:** **Strategy 1:** Increase adoption of electronic prescribing of controlled substances and retrieval of medication history from state PDMP through improved integration of health IT into health care provider workflow.	We support the emphasis on data exchange with state PDMP systems. We strongly encourage the use of non-proprietary standards such as HL7's FHIR US Meds Implementation Guide that will soon include content directly related to PDMP integrations. The immunization community has benefited substantially from the early adoption of interoperability standards, and we encourage this early focus across PDMP as well.

Page Number	Excerpt	Comment
Pg. 66	**Public Health Reporting Recommendation 1:** HHS should convene key stakeholders, including state public health departments and community health centers, to inventory reporting requirements from federally funded public health programs that rely on EHR data. Based on that inventory, relevant federal agencies should work together to identify common data reported to relevant state health departments and federal program-specific reporting platforms. **Recommendation 2:** HHS should continue to work to harmonize reporting requirements across federally funded programs requiring the same or similar EHR data from health care providers to streamline the reporting process across state and federal agencies using common standards.	Although we support harmonization wherever possible, it is important to also keep sight of the very different (and essential) functions provided by these broad public health programs, and the value they bring to our population as a whole. In the case of immunization data, the value is not only to providers (readily available immunization data at the point of care), but to the general public (in protecting our population from vaccine preventable disease). AIRA as a membership organization would welcome the opportunity to provide input from our members on this future body of work.
Pg. 66	Based on an understanding of all EHR-related data requirements across federally funded public health and health care programs that impact most health care providers, HHS can examine and harmonize common data elements and transport standards across reporting requirements.	It is important to recognize that state and local reporting represents the vast majority of the interoperability between public health and clinical care. Given the absence of public health law at the Federal level (it's almost all at the state/local level), public health reporting to the Federal government is often secondary to all the ways public health data meets state and local needs.

Page Number	Excerpt	Comment
Pg. 66	Agencies should then adopt a common standards-based approach to reporting EHR-captured data as a part of their modernization of reporting systems across relevant government programs.	If changes are needed across public health, it will be critically important to increase funding for public health to support design and implementation of these changes. In recent years, an immense increase in volume has been seen in public health reporting due to inclusion in federal incentive programs. A primary obstacle to more commonality is the limited funding that public health receives to implement improvements. We strongly back continued regulatory support for reporting in the areas of immunization, syndromic surveillance, vital records, case report, disease and clinical registries and others. Federal support for public health reporting must remain strong.

AcademyHealth

Medicaid Strategies to Implement Comprehensive Pre-exposure Prophylaxis (PrEP) Clinical Care Services Project

January 24-25, 2019

Sheraton Atlanta Hotel, Valdosta Room
165 Courtland Street NE, Atlanta, Georgia

Meeting Objective: *This meeting will engage representatives from select state Medicaid and public health agencies, as well as other important stakeholders, to explore issues affecting Medicaid beneficiaries' access to HIV pre-exposure prophylaxis (PrEP) clinical care services. Using findings from two Academy-Health commissioned papers as their starting point, attendees will:*

- *Discuss the current state of PrEP clinical care access and delivery within Medicaid.*
- *Explore ways to improve the availability, accessibility, and quality of PrEP clinical care.*
- *Identify approaches for maintaining and extending quality PrEP clinical services amidst scale-up.*

The meeting allows for ample networking opportunities and discussion among state peers.

Agenda

Thursday, January 24

8:00 – 8:45 am **Registration Check-In, Informal Networking Breakfast**

8:45 – 9:00 am **Welcome and Context**
Susan Kennedy, MPP, MSW, AcademyHealth
Raul Romaguera, DMD, MPH, Deputy Director, Division of STD Prevention Centers for Disease Control and Prevention

9:00 – 9:05 am **Project and Meeting Purpose**
Susan Kennedy, MPP, MSW, AcademyHealth

9:05 – 9:45 am **Participant Introductions and Agenda Overview**
Margaret Trinity, MBA, Bailit Health

9:45 – 10:30 am **Keynote: At the Intersection of Health Care and Public Health**
Reed V. Tuckson, MD, FACP
Moderator: William Pearson, PhD, MHA, Centers for Disease Control and Prevention

Dr. Tuckson will situate issues affecting Medicaid beneficiary access to PrEP clinical care within the context of our rapidly evolving health care delivery system, and the health care system dynamics of quality and cost. He will then

share lessons and experiences learned over decades of leadership within the health care system – lessons aimed at enhancing the success of PrEP clinical care in today's rapidly changing health care delivery system. He will discuss the tools and infrastructure that both public health and medical care stakeholders have at their disposal to improve the uptake and delivery of PrEP clinical care.

10:30 – 11:00 am **Networking Break**

11:00 – 12:30 pm **Design and Implementation of PrEP Benefits and Coverage**
Naomi Seiler, JD, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

Ms. Seiler will share key findings from her recent examination of PrEP-related Medicaid benefits and financing options (see White Paper #1). Following initial reactions from a panel of discussants, the audience will explore the applicability and relevance of Dr. Seiler's findings within the context of their own state/institutional personal experiences.
Discussants:
Doug Fish, MD, Medicaid Medical Director, New York Department of Health
Jim Hellinger, MD, Medical Director, Neighborhood Health Plan (MA)

Facilitator: Margaret Trinity

12:30 – 1:30 pm **Lunch**

1:30 – 3:00 pm **Delivering High Quality PrEP Care: Provider Engagement and Support**
Naomi Seiler, JD, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

Ms. Seiler will share key findings from her recent examination of opportunities to educate and engage Medicaid providers around PrEP clinical care (see White Paper #2). Following initial reactions from a panel of discussants, the audience will explore how they might operationalize or otherwise apply Dr. Seiler's results within their own programs and practice settings.
Discussants:
Philip Chan, MD, MS, Medical Consultant, DSTDP, CDC; Associate Professor, Brown University
DeAnn Gruber, PhD, Louisiana Department of Public Health
Facilitator: Margaret Trinity

3:00 – 3:30 pm **Networking Break**

3:30 – 4:45 pm **State Showcase: Lessons from Michigan and New York**

During this session, two states will present their experiences implementing and/or expanding PrEP access and use among Medicaid-beneficiaries—particularly those covered under managed care arrangements. Participants will hear both state and MCO perspectives on challenges and solutions related to PrEP delivery within Medicaid managed care.

Panelists:
Michigan
David Neff, MD, Chief Medical Director, Michigan Department of Health & Human Services (MI DHHS)
Katie Macomber, MPH, Director, Division of HIV/STD Programs, MI DHHS
Dave Rzeszutko, MD, Medical Director, Priority Health

New York
Doug Fish, MD, Medicaid Medical Director, New York Department of Health
Lyn Stevens, Deputy Director, Office of the Medical Director, NYS DOH AIDS Institute
Doug Wirth, MSW, CEO, Amida Care

Responder:
Mike Wofford, PharmD, Chief of Pharmacy Policy, Medi-Cal Pharmacy Benefits Division, California Department of Health Care Services

Facilitator: Susan Kennedy

4:45 – 5:00 pm **Announcements and Day One Adjournment**

Friday, January 25

8:00 – 8:30 am **Networking Breakfast**

Join the day's speakers for breakfast and an informal networking opportunity.

8:30 – 9:30 am **Delivering High Quality PrEP Care: Patient Engagement**

Naomi Seiler, JD, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

Ms. Seiler will share key findings from her recent examination of opportunities to improve Medicaid beneficiary access and engagement in patient-centered PrEP clinical care (see White Paper #2). Following initial reactions from a panel of discussants, the audience will explore ways that Medicaid and public health—alone or in partnership—can better address beneficiaries' specific needs and barriers to accessing care.

Discussants:
Sean Bland, Georgetown University
Elizabeth Hacker, MPH, PrEP Coordinator, Detroit Public Health STD Clinic
Pedro Alonso Serrano, MPH, Hektoen Institute of Medicine

Facilitator: Margaret Trinity

9:30 – 10:45 am **Pulling It All together – Priorities and Pathways for State Action**

In this prioritization exercise, pairs of state teams will huddle to problem solve, identify and document the following:

- Three priority actions for your state—this will vary based on each state's "starting point."
- Tasks associated with each action item, and identify facilitators as appropriate.
- Ways in which public health, Medicaid and MCOs can work collaboratively to implement work plan.
- Guidance, resources, and technical assistance needs.

10:45 – 11:00 am **Break**

11:00 – 12:00 pm **Prioritization Activity Report Out**

States briefly share priority actions and collaborative opportunities identified during their team huddles. Participants will provide input to one another's action items and work plans.

Facilitator: Susan Kennedy

12:00 – 12:15 pm **Closing Remarks and Adjournment**

Susan Kennedy, MPP, MSW, AcademyHealth

Enhancing Provider and Patient Engagement and Education: Medicaid Strategies to Deliver PrEP Intervention Services

Prepared for the CDC, ChangeLab and AcademyHealth as part of the Medicaid Strategies to Implement Comprehensive PrEP Intervention Services project

Naomi Seiler, JD

January 2019

Table of Contents

Thank you to all of the experts who participated in interviews for this project, as well as to those who generously reviewed a draft: Jeffrey Crowley at the O'Neill Institute at Georgetown Law; and Pedro Alonso Serrano, Hektoen Institute. Any mistakes or omissions are the author's.

Funding for this paper was made possible by the Centers for Disease Control and Prevention and ChangeLab Solutions under Cooperative Agreement NU38OT000141. The findings and conclusions of this paper are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Introduction

Pre-exposure prophylaxis, or PrEP, is a highly effective HIV prevention intervention that is dramatically underused, with one recent analysis suggesting that fewer than 1 in 10 people with indications for PrEP in the U.S. are receiving it.[1] Use of PrEP is disproportionately low among African American and Latinx people, as well as lower-income populations.[2,3,4] Between 2015 and 2016, an estimated 1.14 million Americans were eligible for PrEP, but only 90,000 prescriptions for Truvada for PrEP were filled. What's more, utilization showed significant racial and ethnic disparities in use. Though African Americans represent over 45 percent of people with indications for PrEP use in the U.S.,[5] they accounted for only 11.2 percent of PrEP users in 2016.[6] Regional disparities in the HIV epidemic are reflected in lower PrEP use as well: the South accounted for over half of new HIV diagnoses in 2016, but fewer than 30 percent of PrEP users.[7]

Among those who do use PrEP, some may not be receiving the Centers for Disease Control and Prevention's (CDC) full set of recommended PrEP clinical services – such as HIV screening before initiation and quarterly, multisite sexually transmitted infection (STI) screenings. A recent study of providers in San Francisco Public Health Primary Care Clinics found that when initiating PrEP, providers failed to order HIV tests in nearly a quarter of patients, and failed to order STI tests in nearly a fifth of patients.[8] Once patients were on PrEP, providers ordered STI testing in only 72 percent of follow-up intervals.[9]

As part of its work to address these challenges, the CDC is supporting a project, led by AcademyHealth and ChangeLab, to identify ways to improve delivery of PrEP medication and clinical services to the Medicaid population. Medicaid's role as insurance for low-income Americans – particularly since the Medicaid expansion authorized under the Affordable Care Act – makes the program a crucial vehicle for expanding access. Extensive research and practice is underway to try to engage providers in offering, and patients in accessing, the full suite of PrEP medication and clinical services. However, there is little information available on how to drive engagement with and through state Medicaid programs in ways that optimally address provider and patient barriers.

To inform this project, this paper seeks to identify a "menu" of ways to leverage the Medicaid program to educate patients and providers about PrEP and support them in adherence to the medication and clinical services. A separate white paper discusses specific Medicaid financing mechanisms that could be used to improve uptake and comprehensive delivery of PrEP; these include mechanisms to incentivize provider engagement, and the papers should be considered jointly. The papers will inform an AcademyHealth and ChangeLab convening of Medicaid officials from select states, representatives of Medicaid managed care organizations (MCOs), public health officials, and other stakeholders in January of 2019 to consider which of the approaches discussed may be appropriate for their policy environments.

This paper begins with background information on patient and provider barriers to use of PrEP medication and clinical services. It then identifies specific types of educational resources and operational support tools that experts report would be most helpful in promoting engagement, and describes opportunities for dissemination of these resources by Centers for Medicare and Medicaid Services (CMS), State Medicaid agencies, and MCOs, including through partnering with professional societies.

The paper then reviews potential uses of Medicaid claims data to track current PrEP use, assess the provision of clinical services to PrEP users, and identify potential new users. It describes how this data could be combined with surveillance data and other information to help target and shape PrEP education and outreach efforts.

The next section discusses specific Medicaid benefits that may promote provider and patient engagement, including telehealth and medication therapy management by pharmacists. It also describes how some PrEP services could be offered by community-based organizations to support patients and prescribers, and discusses how Medicaid programs and MCOs could support those organizations.

The last section addresses several further considerations for patient and provider engagement through Medicaid, including leveraging cultural competency initiatives in state Medicaid programs, assisting PrEP users experiencing enrollment "churn," creating PrEP linkages for Medicaid-eligible people leaving the corrections system, and parsing privacy issues for adolescent minor PrEP users in Medicaid. It concludes with a discussion of considerations around promoting PrEP for people who inject drugs.

States differ in their HIV epidemics, resources, Medicaid programs, and the relationship between the HIV/public health community and the Medicaid agency. This paper does not present a one-size-fits all answer to promoting PrEP engagement through Medicaid. Rather, the goal is to outline in one place the potential tools that state-level stakeholders could use to better engage and support Medicaid providers and patients through the full PrEP intervention suite. Table 1, below, contains a high-level summary of issues to consider at the state level, based on the topics covered in this paper. After the convening in January 2019, condensed versions of the white papers will be developed as an additional tool to help stakeholders at the state level identify key action items.

Table 1: High-Level Issues to Consider at the State Level

Barriers to Patient and Provider Engagement
Is there state-level data on patient uptake of PrEP medication and clinical services, within Medicaid or overall? Are there quantitative or qualitative assessments of patient barriers to PrEP within the state?

How many and what kind of providers in the state are currently prescribing PrEP, overall and within the Medicaid program? Is there state-level evidence on barriers to provider engagement in PrEP?

Patient and Provider Outreach and Education
What general and state-specific resources would be useful for educating Medicaid enrollees in the state about PrEP?

What resources would be useful for educating current and potential PrEP providers?

What operational tools could help support both patients and providers in uptake of and adherence to PrEP medication and clinical services?

How does the state Medicaid agency communicate with enrollees and with providers?

How do Medicaid MCOs in the state communicate with enrollees and providers?

What opportunities exist for one-time and ongoing inclusion of resources related to PrEP through these communication channels?

Which professional societies would be useful partners for engaging in provider outreach within the state? Which organizations might be willing to work with Medicaid and public health stakeholders to strengthen access to and delivery of PrEP medication and clinical care among Medicaid beneficiaries?

Medicaid Data-Sharing to Target PrEP Resources and Education
What do Medicaid claims data, alone or combined with surveillance or other data, show about current PrEP use in the state? Could Medicaid claims data be used to monitor receipt of PrEP clinical services among current PrEP users?

Could Medicaid claims data be used to inform outreach to potential PrEP users based on indicators such as STI treatment?

Is there an existing data agreement between public health and Medicaid in the state? If not, could the Medicaid agency, or a third party, run analyses related to PrEP?

Are there opportunities for collaborating with specific Medicaid MCOs on analysis of their own claims data?

Using other Medicaid Benefits for Patient and Provider Engagement
How can the state's Medicaid telehealth payment policies be leveraged to expand access to PrEP medication and clinical services for enrollees? What are potential pros and cons of PrEP telehealth models for patients and providers?

Does the state Medicaid program include benefits that could be specifically leveraged to support current PrEP users, such as targeted case management or nonemergency medical transportation?

Does the state have a medical therapy management (MTM) benefit that could be used to pay pharmacists to support current PrEP users and providers? Does the state allow advanced pharmacy practice in a way that would allow further pharmacist engagement in PrEP?

Could community-based organizations (CBOs) provide some PrEP services to make them more accessible to PrEP users and reduce the burden on prescribing providers? If yes, could the CBOs be Medicaid providers or otherwise receive financial support from Medicaid agencies or MCOs?

Further Considerations
How does the state promote cultural competency in its Medicaid program and in partnership with MCOs? Could PrEP and related issues of sexual orientation, gender identify, and race be incorporated into these activities?

Are PrEP providers and users able to navigate shifting Medicaid status, including loss of insurance, changing to private coverage, or switching among MCOs?

Could screening for PrEP eligibility be included in any formal or informal processes for facilitating Medicaid enrollment for people leaving the criminal justice system?

What privacy concerns do the state's Medicaid policies present, particularly for adolescent PrEP users?

How can the provision of PrEP medication and clinical services be integrated into existing services in the state for people who inject drugs, and into new initiatives to address the growing opioid epidemic?

Methodology

AcademyHealth conducted initial discussions with the project Steering Committee (see Appendix 1) to identify the appropriate scope for this white paper. AcademyHealth staff then conducted preliminary interviews with a set of key informants to begin to develop key themes and topics for the convening and white papers. The author then conducted semi-structured interviews with additional experts in Medicaid, PrEP, and patient and provider engagement (see Table 2, below; preliminary interviews conducted by AcademyHealth are marked with an asterisk and all others were conducted by the author).

Interviews of multiple staff at the same organization or agency were combined. All interviews were conducted for the overall project, with insights from the experts incorporated into both white papers.

Table 2: Experts Interviewed for the Project

Divya Ahuja, MD, University of South Carolina Associate Professor of Clinical Internal Medicine

Jennifer Babcock, MPH, Vice President for Medicaid Policy and Director of Strategic Operations, Association for Community Affiliated Plans

Laura Beauchamps, MD, University of Mississippi Medical Center, Assistant Professor Infectious Disease; Medical Director, Open Arms Healthcare Center

Sean Bland, JD, Senior Associate, O'Neill Institute, Georgetown Law*

Sarah Calabrese, PhD, Assistant Professor of Psychology, George Washington University

John Carlo, MD, Member, American Medical Association (AMA) Council on Science and Public Health; CEO, Prism Health North Texas

Stephen Cha, MD, Chief Medical Officer of UnitedHealthcare Community & State

Megan Coleman, FNP, Director of Community Based Research, Whitman-Walker Health, DC

Edwin Corbin-Gutiérrez, MA, Senior Manager, Health Systems Integration, National Alliance of State and Territorial AIDS Directors*

Jeffrey S. Crowley, MPH, Distinguished Scholar and Program Director of Infectious Disease Initiatives, O'Neill Institute, Georgetown Law*

Vanessa Diaz, MD, MSCR, Medical University of South Carolina

Jason Farley, PHD, MPH, ANP-BC, AACRN, FAAN, Co-Director Clinical Core, Hopkins Center for AIDS Research; Immediate-Past President, Association of Nurses in AIDS Care (ANAC)

Douglas Fish, M.D., Medical Director, Division of Program Development & Management, New York State Department of Health*

Andrea Gelzer, MD, MS, FACP, Senior Vice President & Corporate Chief Medical Officer, Amerihealth/Caritas

DeAnn Gruber, PhD, MSW, Director of the Bureau of Infectious Diseases, Louisiana Department of Health*

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The author also conducted a search of peer-reviewed and "grey" literature on Medicaid and PrEP.

Finally, AcademyHealth conducted an informal survey of the participants in its Medicaid Medical Director Network (MMDN) regarding their FFS Medicaid coverage of PrEP medication and clinical care, as well as provider and patient engagement. Deidentified responses received from 16 states are included.

Background

This section provides an overview of the CDC's guidelines for PrEP medication and clinical services, including potential PrEP users and the schedule of recommended services. It then gives a brief overview of patient and provider barriers to engagement – not an exhaustive discussion of the literature, but an outline of key issues. For both patients and providers, it is important to note that knowledge and attitudes may have changed considerably even in the few years since PrEP was formally approved in the U.S. A state-specific assessment could help provide more targeted and current understanding of barriers to be addressed.

PrEP and the CDC's Guidelines

Pre-exposure prophylaxis for HIV, or PrEP, refers to the daily use of a medication by people who are HIV-negative to reduce the risk of seroconversion. Trials have demonstrated effectiveness of over 90 percent for consistent use among those at risk of sexual transmission, and over 70 percent for people who inject drugs.[10] This section outlines the components of the full suite of PrEP services, as well as the people for whom it is indicated, as context for the discussion of engaging patients and providers through Medicaid.

There is only one drug currently approved by the FDA for PrEP in the US: a fixed-dose combination of tenofovir disoproxil fumarate (TDF) 300 mg and emtricitabine (FTC) 200 mg, sold by Gilead as Truvada. FDA granted ANDA approval to Teva[11] and Amneal[12] for generic versions of Truvada in June 2017 and August 2018, respectively. However, neither has yet become available on the U.S. market.

All states must cover Truvada for PrEP in their Medicaid programs, but there is variation across and within states in whether barriers to access exist.

The CDC recommends PrEP be considered as one prevention option for the following people at substantial risk of HIV infection[13]:

Men Who Have Sex with Men (MSMs) (including those who inject drugs)

- HIV-positive sexual partner
- Recent bacterial STI (gonorrhea, chlamydia, syphilis)
- High number of sex partners
- History of inconsistent or no condom use
- Commercial sex work

Persons Who Inject Drugs

- HIV-positive injecting partner
- Sharing injection equipment

Heterosexual Women and Men (including those who inject drugs)

- HIV-positive sexual partner
- Recent bacterial STI (gonorrhea, syphilis)
- High number of sex partners
- History of inconsistent or no condom use
- Commercial sex work
- In high HIV prevalence area or network

In order to determine clinical eligibility, the guidelines recommend a documented negative HIV test result; an assessment to rule out signs or symptoms of acute HIV infection; a renal function test (estimated creatinine clearance); and assessment of current medications to rule out contraindications. While not part of the clinical eligibility criteria, documentation of Hepatitis B infection and vaccination status is recommended prior to initiating PrEP. The CDC recommends that once on PrEP, people receive a follow-up visit at least quarterly for an HIV test, medication adherence counseling, behavioral risk reduction support, side effect assessment, and STI symptom assessment. Renal function testing is recommended at 3 months and every 6 months thereafter. Overall, bacterial STI testing is recommended every 3-6 months for both sexually active men and women. The CDC recommends nucleic acid amplification (NAAT) STI testing at sites of potential sexual exposure including pharyngeal and rectal testing for MSM, as well as rectal testing for women who report engaging in anal sex. Providers should offer pregnancy tests and discussion of pregnancy intent with women every six months, and people who inject drugs should have access to clean needles and drug treatment services.

Overview of barriers to patient engagement

Many factors may hinder patient engagement along the "PrEP care continuum."[14] Key barriers identified in the literature and in interviews for this project include:

- *Lack of awareness:* Since Truvada was approved for PrEP in 2012, public awareness has increased overall.[15] However, there are still some people who could benefit from PrEP who are not aware that the option exists.[16] In the years since PrEP approval, studies have found gaps in PrEP awareness among a range of populations at high risk of HIV. For example:
  - In 2016, over 17 percent of new HIV diagnoses were among young MSM.[17] A study of young MSM across the US (median age 24) between 2013 and 2015 found that roughly a third were unaware of PrEP.[18]
  - In 2016, Black MSM were the most-affected subpopulation in the U.S., representing a quarter of all new HIV diagnoses.[19] It has been estimated that over one half of Black transgender women are living with HIV.[20] However, a study of substance-using black MSM and transgender women in New York City from 2012 through 2015 found that only 18.2 percent were aware of PrEP.[21]
  - Women accounted for 19 percent of new HIV diagnoses in 2016,[22] but less than 5 percent of PrEP users from 2014 to 2016.[23] Focus groups conducted in 2014 with at-risk women in six US cities found that nearly none had been aware of PrEP prior to the focus group.[24]

Awareness may be increasing among these and other groups, but it cannot be assumed that all potential PrEP users are aware of the option.

- *Affordability concerns:* Potential PrEP users may have heard about the costs of PrEP, particularly the medication for people without insurance.[25,26,27] Truvada has an average acquisition cost (the price pharmacies charge without insurer discounts) of approximately $1,600 per month.[28] Though cost sharing in Medicaid is nominal, these concerns may be shared by Medicaid enrollees, particularly if they are unaware that the medication and most clinical services should be covered by their program with minimal cost sharing. Fear of costs can be exacerbated when patients become aware of the additional visits and monitoring, leading to lost work hours and travel costs.
- *Concerns about side effects or drug interactions:* Patients may be concerned about side effects of taking a medication, especially for preventive purposes. However most PrEP users experience no side effects, and among the 8-10% who do (headache, upset stomach), they last only a few days. Concerns about PrEP reducing the effects of hormone therapy have been reported among transgender women.[29] To date, there are no substantive data available to corroborate these concerns. However, preliminary data do suggest that hormone therapy for transgender women can lower the efficacy of PrEP.[30]
- *Geographic barriers:* Multiple interviewers cited geography as a barrier for patients, particularly in rural settings.[31] Patients are unable to travel long distances to PrEP providers in cities, particularly for quarterly visits for monitoring and testing. Transportation can also be a barrier to regular visits for PrEP users in urban settings.[32]
- *Lack of relationship with a trusted provider who offers PrEP:* Some potential PrEP users may not have a relationship with a trusted provider who could prescribe PrEP. For example, a study of MSM in Oklahoma noted that a combination of geographic barriers and a dearth of "affirming providers" were commonly reported as barriers by MSM.[33] One interviewee who offers PrEP navigation at a public STD clinic noted that some transgender and MSM patients express not feeling comfortable discussing PrEP or sexual history with some prior providers.[34] For women, family planning clinics may be their primary or only source of trusted health care, and these providers do not always offer or discuss PrEP.[35] As discussed later in this paper, though people who inject drugs accounted for 10 percent of new HIV diagnoses in 2016, many substance use treatment providers also do not offer PrEP.
- *Perceived provider stigma:* Lack of a relationship with a trusted provider is related to perceived (and often real) provider stigma or bias. One study based on online focus groups with MSM from different parts of the country found that "[w]hen participants were asked if they would feel comfortable discussing PrEP with their own primary care physicians (PCPs), most indicated discomfort due to embarrassment or fears of being judged."[36] Stigma is multifactorial and will likely vary based on setting and other factors; for example, a study that compared focus groups of White MSM in Boston with Black MSM in Jackson found that the latter group were more likely to report provider stigma around HIV and sexual orientation.[37]
- *Internal stigma:* Potential PrEP users may also have internal biases against PrEP use. For example, in one study surveying black MSM and transgender women at a pride event in 2015 in a large southeastern city, 23 percent stated that PrEP was "for individuals who are promiscuous"; this belief was associated with lack of interest in using PrEP.[38] Similarly, a study of heterosexual, HIV-negative women who are Planned Parenthood patients in three high-prevalence Connecticut cities found:

Participants commonly perceived PrEP-user stereotypes, with many believing that others would regard them as promiscuous (37%), HIV-positive (32%), bad (14%), or gay (11%) if they used PrEP. Thirty percent would feel ashamed to disclose PrEP use. Many participants expected disapproval by family (36%), sex partners (34%), and friends (25%).[39]

The study found these perceptions to be negatively associated with comfort discussing PrEP with a provider and intention to use PrEP.[40]

Upcoming Resources on Barriers to Patient Engagement in PrEP

Four NIH-funded national cohort studies of cis, trans and gender non-conforming young men, women, and others, ages 13 and older, will begin releasing data in 2019.[181] These studies will provide further information on barriers to engagement in PrEP among these populations, helping inform national and state solutions.

Overview of barriers to provider engagement

Based on the literature and interviews conducted for this project, key barriers to provider engagement with PrEP overall include:

- *Awareness:* Since the approval of Truvada for PrEP in 2012, provider awareness has grown, but many providers are still not fully informed about PrEP. For example, one 2015 survey of academic primary care physicians found that while nearly all were aware of PrEP, two-thirds of them had not prescribed it; of these non-adopters, over 55 percent rated their knowledge of PrEP as poor or fair, and over 65 percent rated their knowledge of PrEP side effects as poor or fair.[41] In the study, self-rated knowledge of PrEP was associated with prescribing it; another study found that *actual* knowledge of PrEP (as measured with a 5-question test) was also associated with prescribing as well as intent to prescribe in the future.[42]

  Knowledge of PrEP among primary care physicians is, predictably, lower than among HIV specialists. An online survey of primary care physicians and HIV physicians found that primary care physicians were less likely to have heard of PrEP (76 percent vs. 98 percent) or to report familiarity with prescribing it (28 percent vs. 76 percent).[43] A more recent survey of primary care physicians in a university health system in North Carolina found low rates of PrEP prescribing, with "lack of knowledge" being the largest reported barrier.[44]

- *Lack of skills/experience:* Some providers may lack the skills to comfortably elicit sexual histories. For example, the study comparing primary care physicians and HIV experts found that fewer primary care physicians reported feeling "somewhat or completely comfortable" discussing sexual activities (75 percent vs. 94 percent).[45] Primary care providers may also be reluctant to begin prescribing antiretroviral medications,[46] a class with which few have experience. However, interviewees stated that overall, PrEP is a relatively simple intervention for primary care providers to manage,[47,48] and that efforts to engage more providers should not overstate the necessary skills.

- *Confusion regarding scope of guidelines:* One interviewee noted that the current CDC PrEP guidelines still leave ambiguity regarding patient criteria, and that they could potentially exclude patients who would in fact benefit from PrEP.[49] An alternative approach would be the "routinizing" of PrEP – making it a routine discussion with all adult patients.[50] In addition to preventing under-reach, this approach could help reduce the impact of bias in provider decisionmaking regarding PrEP. However, depending on implementation, this could add further burden to providers with limited time with patients.

- *Time/capacity:* Multiple interviewees noted that even when providers have the skills and willingness to counsel patients about PrEP, they may lack the time in a primary care visit with multiple other health issues to address.[51] One interviewee reported that the CDC-recommended guidelines for ongoing STI testing may be daunting for primary care providers.

- *Concerns about unintended consequences:* Across multiple studies, providers report concerns about the unintended consequences of PrEP, including the development of resistance; potential lack of adherence; and the possibility of risk compensation, i.e. PrEP users increasing risky behaviors.[52,53,54,55]

- *Questions about cost and reimbursement:* Some providers are unaware of how to seek reimbursement for PrEP, or how to assist patients in accessing PrEP without burdensome cost sharing.[56]

- *Lack of clear sense of responsibility for PrEP:* Many HIV specialists believe that scale-up of PrEP needs to occur in the primary care setting where most persons without HIV infection get care, yet many primary care providers believe they lack the time and expertise to offer PrEP, a dilemma described by Krakower et al. as the "purview paradox."[57] Meanwhile, while STD clinics may be seen as a logical place to reach people at high risk of HIV, a lack of funding and capacity may be challenges. One interviewee noted that STD clinics may aim to start patients on PrEP and transition them to a primary care provider[58], but that referrals could lead to lower persistence in PrEP use.[59]

  Overall, there was consensus among interviewees that more providers need to offer PrEP services, and most interviewees for this project concurred that uptake among primary care providers is crucial.[60] However, one interviewee opined that in a practice with only a handful of PrEP-eligible patients, it may make more sense to refer them to providers with substantial numbers of PrEP patients than to manage them directly.[61]

- *Stigma and Bias:* Provider resistance to engaging in PrEP can be rooted in conscious or subconscious bias based on race, sexual orientation, gender identity, sexual behavior, socioeconomic factors, or a combination. For example, one study that presented medical students with a vignette involving an MSM patient seeking PrEP found that participants reflecting higher levels of heterosexism were more likely to anticipate adherence problems and risk compensation, leading to lower intention to prescribe.[62] Another study of medical students found greater belief that a hypothetical black patient would engage in risk compensation compared to a white patient, a factor that again was associated with reported lower likelihood to prescribe.[63] Studies of MSM in varied geographic settings have found perceived provider stigma to be a barrier to asking about PrEP or discussing relevant sexual behaviors.[64,65]

  Bias may be an issue among other staff in medical settings. Implicit (or explicit) bias among receptionists, nurses and other staff can affect patients' willingness to utilize or even ask about PrEP.

Providers and PrEP: the Information-Motivation-Behavioral Skills Model

The Information-Motivation-Behavioral Skills, or IMB, model, could be one framework for considering provider engagement in PrEP.[182] Information would involve making providers aware of PrEP and addressing misconceptions. Motivation could be extrinsic (e.g. CME requirements, set protocols) and intrinsic (getting provider buy-in, based on PrEP's unique benefits, such as being user-controlled, private, effective for both PWID and sexual risk, and effective for discordant couples, including those who wish to conceive). Finally, behavioral skills can be developed through concrete guidelines and resources, including checklists, scripted language, hands-on training and education materials (see below for further discussion of specific materials and resources).

Leveraging the Medicaid program to engage patients and providers

This section provides an overview of resources to educate patients and providers about PrEP and of operational tools to support adherence to the medication and clinical services. It then describes how these resources could be disseminated in the Medicaid program by three potential "messengers": CMS, state Medicaid agencies, and Medicaid MCOs. State Medicaid agencies or MCOs can work with public health stakeholders to identify the appropriate set of resources, messages and communication channels for distribution within a given state or region.

Patient and provider educational resources and operational tools

This section describes the scope of resources that could be used to educate and inform patients and provider about PrEP, and the operational tools that could help support continued engagement in PrEP among provider and adherence among PrEP users.

Patient and provider educational resources

There are a wide range of resources that could be shared with patients and providers to educate them about PrEP. In collaboration with Medicaid agencies and MCOs, public health agencies may play a role in the development of any new or specifically tailored materials. Existing examples of many of these resources are available, for example through Project Inform at www.projectinform.org/prep/.

For patients, information could include:

- Culturally competent and accessible information about PrEP services.
- State-specific information on how Medicaid covers PrEP medication and clinical services.
- PrEP locator information (i.e. a url for a site for finding PrEP providers). The existing website https://preplocator.org is a searchable directory of clinics and providers who offer PrEP. It is not exhaustive – relying on direct submissions or confirmations from providers – but may be a good starting point. Some health departments have developed their own PrEP provider directories, using the central preplocator tool or their own maps.[66] Optimally, a directory would include information on how to find a PrEP provider participating in the Medicaid program (as included in the directory provided by the North Carolina AIDS Education and Training Center)[67] or in specific Medicaid MCO networks.

For providers, based on the literature review and interviewees, the following educational resources could be considered for dissemination through the avenues described in this section.

- **The CDC's PrEP guidelines and provider education tools**. Multiple interviewees noted that providers would consider the CDC's existing guidelines to be a trusted source of information. While some providers – or patients – may find their way to the guidelines online or through other sources, they and any future updates should remain a key component of provider outreach, along with the CDC's PrEP education resources and tools for providers.[68]
- **State-specific information**. Multiple interviewees noted that providers would benefit from state-specific information. This could include:
  - Any relevant recommendations or guidelines from the state DOH. For example, DC has developed a provider guide with District-specific PrEP and PEP information and guidelines.[69]

  - Information about the state's Medicaid program and parameters for coverage of PrEP medication and clinical services, including billing and coding information.

- **Education on taking sexual histories.** One interviewee noted that sexual histories should be part of routine medical care, beyond just a screening tool for PrEP[70]; similarly, another noted that discussing sexual history can be useful for some patients even if they are not ready for PrEP.[71] Resources for providers could include materials on taking sexual histories, such as SIECUS's guide to taking sexual histories for providers serving LGBT youth.[72]
- **Continuing education on PrEP**. Providers should be made aware of continuing education (CE) resources on HIV prevention, including PrEP. In general, CE is available for physicians as well as nurse practitioners, physician assistants, and registered nurses. CE on PrEP could increase knowledge while allowing providers to meet their state-level requirements.
- **Availability of PrEP academic detailing**. A number of states and cities have developed "academic detailing" programs on PrEP, offering training to providers to increase adoption of PrEP prescribing as well as of CDC-recommended clinical services.[73,74,75] Providers could be informed of the availability of any such opportunities in their state or region.
- **PrEP Locator Resources**. As an interviewee noted, the Preplocator.org directory or state-specific directories may be useful not only for patients but also for providers, allowing prescribers who are new to PrEP to contact other providers in the area with initial questions or for ongoing peer support.[76]

The U.S. Preventive Services Task Force

A positive recommendation from USPSTF could represent an important opportunity for engaging patients and providers, both through and outside the Medicaid program.

First, within Medicaid, the elimination of some cost-sharing for expansion enrollees could be an important shift. While Medicaid cost sharing is generally "nominal" and in most states must be waived by providers and pharmacies if requested, even small out-of-pocket costs can be a deterrent to care. In addition, the perceived cost of PrEP may be a barrier to patient access, even though costs for Medicaid enrollees would be relatively modest. To the extent PrEP can be advertised as entirely free for Medicaid patients, concerns about cost could be reduced as a barrier for Medicaid enrollees.

Second, many interviewees agreed that a positive USPSTF recommendation for PrEP could encourage more providers, particularly primary care providers, to offer the service. Therefore, a positive recommendation could help address the "purview problem" by specifically validating PrEP as an intervention that belongs (though not exclusively) in the primary care setting.

Operational support tools for patients and providers

In addition to educational materials about PrEP, both providers and patients could benefit from a range of operational "tools" and resources to support ongoing provision of, and adherence to, PrEP medication and clinical services. While some of these supports would be specifically provider-facing – such as workflow models for PrEP delivery – others, such as text platforms, could support both patients and providers by facilitating reminders and communication.

- **Workflow sheets or algorithms**. Providers, particularly those new to PrEP, could benefit from a workflow model or algorithm that walks through the steps of PrEP offer, initiation, and ongoing monitoring.[77,78,79] For example, the New York State Department of Health developed quick reference cards for PrEP that could be attached to provider lanyards for clinical use.[80] One interviewee described educational materials she developed for Planned Parenthood's PrEP provider training program, which included scripted language for patient encounters.[81]
- **Standardized prior authorization form.** It may be appropriate to develop clear, standard prior authorization (PA) forms for PrEP medication to simplify requests on the provider side. While PA can in theory pose a barrier to access to PrEP, a simple form linked to relevant clinical information (e.g. demonstrated HIV-negative status at initiation) may be less of a barrier.
- **Consumer communication tools.** One interviewee, a PrEP navigator, reported that her calls to current PrEP users – to remind them of followup visits or to check on patients who miss visits – help promote compliance with ongoing monitoring.[82] She noted that a texting program for PrEP users could also be helpful, possibly for medication reminders or allowing questions by text. As noted in the textbox below, the VA's toolkit for PrEP engagement includes PrEP-specific messages in the system's text messaging system. A text message platform for youth PrEP users was recently found to increase PrEP adherence among youth at high risk of HIV acquisition[83]; the tool will be integrated into larger demonstration projects.[84]
- **Patient screening tools**. Interviewees noted that both patients and providers would benefit from simple patient screening tools. Multiple interviewees recommended disseminating questionnaires that patients could complete on their own, either before a visit or while waiting in the waiting room or exam room.[85,86] These tools could make some patients more comfortable answering questions related to sexual history. In addition, they would save provider time, and address the barrier of discomfort taking sexual histories for some providers. Such tools are already available; for example, the CDC has developed a six-question MSM risk index for PrEP and a seven-question risk index for people who inject drugs.[87] The Stigma Project has developed the CDC guidelines into a user-friendly screening tool.[88]

- **Patient counseling supports.** Providers and patients could benefit from tools to help PrEP users remain engaged. For example, the Integrated Next Step Counseling model, developed for the iPrEx study, guides providers through a patient-centered discussion of PrEP, with an emphasis on PrEP adherence.[89]
- **National Clinical Consultation Center**. The National Clinician Consultation Center at UCSF, funded by the CDC as part of the Health Resources and Services Administartion's (HRSA) AIDS Education and Training Center (AETC) program, has a provider warmline (PrEPline) offering free phone consultations to provide clinical advice on PrEP.[90] Medicaid programs and MCOs could also disseminate information on training opportunities from other AIDS Education and Training Centers.[91]
- **Other expert consults.** One interviewee noted that it would be helpful to have some kind of reimbursement for PrEP "peer support" for primary care providers.[92] Another interviewee who is an infectious disease doctor serves as a peer consult on PrEP within the clinical network that employs him, offering support usually via email. These consults are not reimbursed by Medicaid or other payers.[93] Similarly, a different interviewee conducts a Project ECHO-type consultation model for PrEP for primary care providers within his state; participants get CME credit, but no reimbursement.[94]

Conduits for engaging patients and providers through the Medicaid program

This section discusses how PrEP education resources and operational support tools could be disseminated by CMS, state Medicaid agencies, and MCOs. It also describes potential partnerships with professional societies to amplify provider engagement efforts.

CMS level

CMS administers the Medicaid program at the federal level. Generally, the agency is fairly removed from direct interaction with Medicaid patients and providers, communicating instead with state Medicaid agencies through Dear State Medicaid Director Letters, Informational Bulletins, and other guidance documents.[95] However, CMS did mention provider PrEP education in a 2016 joint informational bulletin with HHS, HRSA, and the CDC:

> Additional strategies states may consider to ensure that utilization management techniques are not designed or implemented in ways that amount to denial of access to PrEP among persons for whom it is indicated include 1) provider education, 2) development of clear policies and procedures for assessing and making determinations about indications for PrEP, and 3) careful review and monitoring of Medicaid FFS and managed care benefits and coverage.[96]

Veterans Health Administration: PrEP Materials and Resources for Patients and Providers

The VA convened a National PrEP Working Group in 2017 to develop targets for PrEP uptake.[183] To begin to meet these goals, the VA developed a set of products to increase uptake and awareness across the system; these included a PrEP awareness communication tool, PrEP training modules for providers, a VA blog on PrEP, and AIDSVu reports showing regional HIV risk. Further materials included academic detailing training modules and virtual PrEP training for clinical pharmacists. To facilitate targeting of PrEP to high-risk groups, the VA developed clinical support tools to identify candidates for PrEP, telehealth protocols for PrEP, and social media awareness campaigns.

- The VA also developed a set of clinical support tools to specifically address the quality of ongoing clinical care for PrEP users, including lab monitoring. These tools include:
- a set of clinical considerations, aligned with the CDC's guidelines;
- a "PrEP clinical criterion check list";
- other clinical support tools, including prepopulated EHR templates and order menus for PrEP initiation and monitoring; and
- PrEP-related texts in the VA's text-messaging system, to support adherence, appointment attendance, tracking, and patient education.[184]

Building on items 1 and 2, the CDC could ask CMS to consider disseminating materials to inform specific provider education at the state level, as well as tools for developing clear procedures for providers to help them make determinations about which patients are candidates for PrEP. These provider capacity assessment and support tools could be modeled on the approach CMS has taken with regard to substance use disorder, offering clinical resources guides, a national workshop, and a range of webinars, both live and archived.[97]

The CDC could also collaborate with HRSA's Bureau of Primary Health Care (BPHC) to address patient and provider issues at FQHCs.

State Medicaid agencies

State Medicaid agencies could disseminate PrEP resources through a range of communication channels, identified through interviews for this project as well as AcademyHealth's informal survey of its Medicaid Medical Director Network (MMDN).[98] For patients, states could include brief information about PrEP in initial enrollment materials and ongoing mailings to enrollees. Some respondents to the MMDN survey also reported using enrollee emails and automated calls.[99] An important caveat noted by two MMDN

respondents is that in states with high managed care enrollment, states might not communicate directly with enrollees.

State Medicaid agencies could use their agency websites to highlight key PrEP resources both for patients and providers, including specific information on coverage for both, as well as on billing and coding details for providers. Some states may have specific sites for information related to pharmacy; for example, California Medi-Cal's Drug Use Review program has an educational intervention component regarding drug-specific therapy issues.[100]

State Medicaid agencies can also reach providers through a range of approaches:

- *Provider manuals.* Provider manuals can lay out service standards for provision of PrEP medication and clinical services, as well as links to resources for further education and support.
- *Emails and/or newsletters to providers.* Most state Medicaid agencies have regular communiques to providers noting updates such as formulary or billing changes, or highlighting certain key policies. For example, New York State's Medicaid program sends a monthly update to providers, largely focused on billing and policy issues.[101] These communications may be electronic; five of the sixteen respondents to AcademyHealth's survey specifically noted email as an effective way to reach providers.[102]
- Some newsletters may be read more often by administrative staff than by providers themselves and therefore may be appropriate outlets for highlighting and providing links to key PrEP billing and coding resources.
- *Direct letters to providers* regarding PrEP. The State Medicaid agency could send letters to all Medicaid providers in the state, or to targeted subsets, specifically highlighting PrEP resources.
- State Medicaid agencies could also use "all-plan letters" to encourage MCOs to share PrEP information with participating providers and with enrollees.

Examples of State Medicaid Outreach to Medicaid Providers

In December 2017, California's Department of Health Care Services sent a notice to all Medi-Cal providers regarding erroneous delays and denials of PrEP and PEP, and clarifying that both are covered services available through Medi-Cal.[185]

In New York, the Department of Health (DOH) learned of provider confusion over Medicaid coverage of PrEP and PEP in Fee for Service Medicaid. DOH developed a document for distribution to all Medicaid FFS providers to clarify coverage policies.[186]

Lessons from MCO Provider Engagement Efforts Related to Medication-Assisted Treatment for Opioid Addiction

A recent report for the Association for Community-Affiliated Plans detailed the strategies that several Medicaid MCOs are using to support and engage primary care physicians in prescribing Medication-Assisted Treatment (MAT) for opioid use disorder.

The authors of the report identified provider barriers to offering MAT that in several ways echo those involved with PrEP: a lack of provider education, the additional management burden of MAT practice, and stigma related to the patient population and to the underlying risk behavior.

Medicaid MCOs profiled in the report used a variety of approaches to engage new MAT providers and to support and maintain existing providers. For example:

- UPMC (Pa.) supports educational sessions in medical schools, as well as training opportunities for providers, including webinars, conferences, and on-site presentations.
- UPMC supports physicians who are on call at all hours to answer questions from prescribing physicians, as well as a 24-hour care management services for patients and providers.
- Community Health Network of CT offers a two-day conference on addiction, opioid use disorder and MAT, with 16 free CME credits, for its providers. It also offers online toolkits for primary care providers and emergency room-based providers.
- Inland Empire Health Plan (CA) has a payment structure that support out-of-office time for trainings related to MAT.
- Multiple MCOs support Project ECHO models related to opioid use. For example, Passport Health Plan (Ky.) is engaged in a Project ECHO collaborative to support buprenorphine prescribing, particularly for rural providers; and Partnership Health Plan (Calif.) uses the ECHO model to train primary care providers on treating chronic pain. Partnership Health Plan has also engaged a MAT provider who visits network practices to support MAT implementation.
- Three health plans – Inland, Passport, and UPMC – are developing consistent screening processes to identify patients with opioid use disorder. Geisinger Health Plan uses ICD codes to identify candidates for targeted outreach.
- Geisinger Health Plan conducted an internal survey of its physicians regarding addiction in SUD, in part to identify and address provider bias and stigma.

It is important to note that state Medicaid agencies may be concerned that patient or provider outreach will drive a demand for PrEP that the state cannot afford to meet.

Medicaid MCOs

MCOs can provide information directly to their own enrollees. Enrollee MCO manuals could include basic information on PrEP and how to learn more, as well as information on finding a PrEP provider specifically within that MCO's network. MCOs could

also send information about PrEP to all members or to specific zip codes, targeted based on Medicaid claims data analysis and/or state surveillance data.[103]

Medicaid MCO websites usually have both enrollee and provider interfaces. The enrollee website could link to basic consumer information about PrEP and how to access it; the provider interface, targeted to in-network providers, could highlight provider resources on PrEP.

MCOs can reach out to providers through additional channels:

- *Provider manuals*: Provider manuals can lay out service standards for provision of PrEP medication and clinical services, as well as links to resources for further education and support.
- *Provider mailings:* Like state Medicaid agencies, MCOs routinely send regular or special communications to providers on key coverage or policy issues, which could highlight PrEP resources. This outreach could be targeted based on Medicaid claims data analysis and/or state surveillance data.[104]
- *CME:* Medicaid MCOs can highlight, sponsor, or otherwise promote CME for their providers. MCOs could work with public health agencies to incorporate PrEP-related provider education into these opportunities.
- *Medical Affairs:* MCOs' Medical Affairs offices can reach out directly to providers for informational engagement on a range of clinical topics,[105] and could consider including PrEP in the scope of this outreach.

Finances are a crucial consideration for MCOs. MCOs may be hesitant to engage in patient and provider outreach if they are concerned that the rates they receive from the state would not adequately reimburse any ensuing uptake in PrEP medication and clinical services.

Partnering with provider organizations

Multiple interviewees cited the CDC as a primary source of trusted information for providers, including primary care providers, reinforcing the idea that Medicaid programs could add value simply by highlighting the CDC's PrEP guidelines and resources. However, interviewees also noted a range of other professional societies to which providers turn for information. Of 16 state Medicaid Medical Directors responding to AcademyHealth's informal survey for this project, five specifically noted the important role of medical professional societies in helping reach providers.[106] Medicaid agencies, MCOs, and public health agencies could reach out to these professional organizations at the national, state, and/or local levels to identify opportunities for promoting PrEP engagement and education among providers.[107]

Provider organizations could also work closely with Medicaid agencies and MCOs to help assess and strengthen policies related to coverage of PrEP medication and clinical services. Alternative financing opportunities may be more likely to come to fruition if providers, as well as public health stakeholders, are engaged in the process.

Multiple interviewees noted that providers often trust information developed at the state level as particularly responsive to their and their patients' needs. This would include state-level chapters of the organizations discussed below, as well as information from respective State Departments of Health.

Several organizations already have longstanding relationships with the CDC's Division of HIV/AIDS and could be strong partners in continued work to promote PrEP access within Medicaid. The National Medical Association represents more than 50,000 African American physicians and their patients, and promotes professional education and scholarship as well as responsive health policy and consumer education.[108] The National Hispanic Medical Association represents 50,000 Hispanic physicians in the U.S. and also engages in provider and patient engagement as well as policy work.[109] The American College of Physicians serves a similar role with regard to internal medicine specialists and subspecialists.[110]

Other professional societies could represent further opportunities for reaching and supporting new PrEP providers and patients. Affiliates of three, the AMA, AAFP, and AANP, were interviewed for this project:

- **American Medical Association (AMA)**: The AMA is a professional organization for all physicians, both MDs and DOs, as well as medical students. In 2016, the AMA adopted a policy supporting improved provider education on PrEP for HIV, noting that a 2015 survey had found that 34 percent of primary care physicians and nurses had never heard of the intervention.[111] The AMA simultaneously endorsed policies in support of full insurance coverage of the costs associated with PrEP as well as the development of policies to provide PrEP for free to high-risk individuals.[112]

  Nationally, the AMA has several member groups, or "Sections," that may be particularly interested in PrEP; these include the Advisory Committee on LGBTQ Issues and the Minority Affairs Section.[113] The AMA also maintains a "Federation of Medicine" directory of state-level medical associations, including specialty associations. The directory includes society names, leadership, contact information, and websites.[114] Stakeholders could use this resource to identify state-level physician societies and discuss ways to work together to promote AMA's policy on PrEP education.

- **The American Academy of Family Physicians (AAFP)**: The AAFP is a membership organization for family physicians who serve patients of all ages in a wide variety of settings, including offices, hospitals, community health centers, urgent care centers, and emergency rooms.[115] It currently has 131,400 members, including medical students and residents.[116] The AAFP develops practice guidelines for family physicians. These are often based on US Preventive Services Task Force recommendations: the AAFP reviews all USPSTF clinical preventive services recommendations and develops its final recommendations based on the evidence base from the USPSTF. AAFP's current policy on "Prevention and Control of Sexually Transmitted and Blood Borne Infections" states that "[f]amily physicians should counsel and when appropriate prescribe PrEP as a routine part of STI prevention."[117]

  The AAFP has 55 constituent chapters that are involved in education, messaging and promotion for family physicians within the state. They often follow national priorities, but can engage on specific issues independently, and may be open to approach for collaboration on PrEP issues.[118] Stakeholders should consider reaching out to their states' AAFP chapters regarding state-specific opportunities for increasing PrEP access in the state's Medicaid program and overall.

- **The American Academy of Nurse Practitioners (AANP)**: The AANP is a national provider organization for Nurse Practitioners across all specialties, as well as nursing students. AANP is viewed as a key source of education and information driving NP practice, including by hosting CME and other educational materials on its website.[119]

- The AANP also maintains an online directory of state, local, and regional organizational members.[120] Stakeholders could reach out to relevant organizations in the state to discuss potential collaboration on PrEP education and promoting PrEP through Medicaid.

Other professional societies to consider including in PrEP planning and engagement efforts include, but are not limited to, state primary care associations and state chapters of the American Academy of Physician Assistants and the American Academy of Pediatrics. In addition to professional societies, stakeholders should consider partnering with organizations that represent specific types of facilities. For example, NACCHO, the National Association of County and City Health Officials, has an educational series on PrEP for local health departments.[121]

Using Medicaid data to target PrEP resources and education

Multiple interviewees agreed that Medicaid claims and encounter data could be leveraged to increase PrEP uptake and adherence and to improve provision of PrEP clinical services to current PrEP users. Because Medicaid agencies do not always have staffing or resources to spare for new analyses,[122] public health stakeholders could develop or expand existing data sharing agreements with state Medicaid agencies, or work together to identify a third party, such as a university,[123] that could conduct the analyses.[124]

In an important caveat, two interviewees noted that "real-time" use of Medicaid claims data is generally not feasible,[125] due in part to lags in claims processing.[126] Despite this limitation, Medicaid claims data could potentially be used in at least three ways:

- Identifying the current rate of PrEP use in the Medicaid program, including stratification by certain populations;
- Tracking the provision of clinical services to current PrEP users;
- Identifying candidates for PrEP, based on STI-related claims or other indicators from Medicaid data.

These analyses and any related outreach to providers or patients would need to be conducted in line with existing privacy agreements as well as community expectations.

Measuring current PrEP use in the Medicaid program

First, Medicaid claims data can be used to identify who is receiving PrEP. New York State's AIDS Institute applied an algorithm to state Medicaid pharmacy and diagnosis data to identify enrollees who were on Truvada for more than 30 days,[127] excluding those with an HIV diagnosis.[128] In California, a recent analysis of PrEP uptake among Medi-Cal beneficiaries looked at changes in utilization from 2013 to 2016, stratifying data by age, gender, race, ethnicity and region to assess patterns and disparities that could help guide public health efforts to promote uptake.[129]

Similar analyses in other states could help establish a baseline for PrEP use among Medicaid enrollees and allow tracking of the impact of Medicaid-specific or statewide promotion efforts. The CDC's recent paper estimating the number of adults with PrEP indications includes figures by state and includes stratification by transmission risk group and race/ethnicity,[130] making it a useful tool for comparing PrEP access in the Medicaid program to estimated need. Identifying active PrEP prescribers in Medicaid can help states determine if communities with high PrEP need – e.g. with high STI rates – have sufficient access. Stakeholders may also wish to explore potential integration of Medicaid claims data with AIDSVu data on PrEP use.[131]

An important limitation is that data on race is often missing from Medicaid claims. In addition, claims data do not capture gender identify or sexual orientation, limiting the ability to answer certain key access questions.[132] This is one effect of an overall lag in SOGI (sexual orientation and gender identity) data collection in Medicaid programs, posing a challenge for assessment of baseline need and progress in reaching people with PrEP and other services.[133]

A further limitation is the lookback period could result in somewhat outdated utilization counts. Nonetheless, such an analysis would offer some important baseline information about how well a state Medicaid program is reaching enrollees with PrEP.

Tracking provision of clinical services to current PrEP users

Medicaid claims data could also be used to track whether people currently using PrEP are also receiving appropriate clinical services. For enrollees identified as PrEP users based on the type of analysis described above, a *lack* of claims for STI screening or other components of PrEP services could indicate that appropriate clinical services are not being provided.[134]

Claims-based analyses would only identify services reimbursed by Medicaid, omitting, for example, screenings obtained at a non-billing STI clinic.[135] However, this approach could at least flag patterns (by region or provider) of potential non-receipt of appropriate services. Such an analysis could potentially be utilized to inform targeted provider outreach, either by Medicaid agencies or public health counterparts.

Finding candidates for PrEP

Medicaid claims data could also be used to identify enrollees who are candidates for PrEP. For example, certain STI diagnoses within Medicaid claims might indicate patients whose providers could be encouraged to offer information about PrEP. Such information could also potentially be found in state surveillance data[136]; for example, Michigan's "Data to PrEP" program uses surveillance data to identify and conduct PrEP outreach to HIV-negative men with a single rectal gonorrhea infection, two urethral or pharyngeal gonorrhea infections, or syphilis. Incorporating Medicaid claims data into such initiatives might help fill gaps left by incomplete reporting to departments of health.

Medicaid Claims Data and MCOs

Generally, State Medicaid agencies have access to all claims data for their enrollees, whether FFS or managed care. However, MCOs receive their own payment data first, and may have relatively sophisticated analysis capacity.[187] In some states, it may make sense for MCOs to conduct PrEP-related data analysis for their own covered populations. In all states with MCO enrollment, Medicaid agencies, MCO, and public health stakeholders can work together to ensure reporting of those elements of encounter data that are important for PrEP analysis.

Leveraging Medicaid benefits for patient and provider engagement

This section describes specific Medicaid benefits that could be leveraged to better engage patients and/or providers in the full PrEP intervention suite. The section reviews PrEP and telehealth in Medicaid; as well as additional Medicaid benefits, like nonemergency medical transportation, that could assist PrEP users. It also discusses how Medicaid can support both pharmacists and non-clinical CBOs in bolstering patient and provider engagement.

PrEP and telehealth in Medicaid

Telehealth options for accessing PrEP could increase patient access, mitigating both geographic and other barriers to care.

As of spring 2018, 49 states and DC provide for Medicaid reimbursement of some form of live video telehealth services.[137] Roughly half of states specify a specific set of facilities that can serve as "originating sites" where the patient may be; only ten states permit a patient's home to be the originating site.[138] Telehealth coverage in Medicaid can vary by service type. Among MCOs, for example, a 2017 survey found that 37 percent of Medicaid MCOs use telemedicine for mental health or SUD counseling, along with 20 percent for chronic disease management; 32 percent did not use telemedicine.[139] In addition, some multistate Medicaid MCOs provide their enrollees with free access to national telehealth service providers, such as Teladoc.[140]

Several telehealth models for PrEP exist. For example, in New York State, the AIDS Institute identified rural counties with limited PrEP access.[141] They then worked with an FQHC in the region that had engaged in HIV treatment telehealth to establish a system for PrEP telehealth. The FQHC reached out to clinics in the underserved communities to begin providing PrEP to patients at those clinics, with the local providers present in the room so they could become comfortable with PrEP provision themselves.

Louisiana recently launched a Tele-PrEP program. Via a HIPAA compliant video platform, patients can use a computer, tablet, or smartphone to interact with a nurse practitioner located in New Orleans; a tele-PrEP navigator connects the patients to lab services.[142] For patients with Medicaid, Medicaid will pay for the drugs.

In one current trial of telehealth vs. standard PrEP, patients see a provider on camera, and HIV and STI kits are sent to the home for self-swabbing and finger sticks.[143] Subjects' insurance pays for the telehealth encounters, but study funds are being used to purchase the home test kits. If such a model is identified as an effective approach more broadly, it may be important to identify an avenue for Medicaid or alternative reimbursement of at-home test kits.

Additional Medicaid benefits to support PrEP Users

A number of additional Medicaid benefits could be leveraged to promote patient access to PrEP by addressing barriers to access and adherence:

- Targeted Case Management: Medicaid programs can support Targeted Case Management for specific groups of enrollees. Rhode Island has expanded this concept to make TCM available for certain beneficiaries at high risk of HIV,[144] creating a reimbursement mechanism for services around linking people to PrEP and encouraging their adherence to PrEP clinical services.
- Care Coordination: Many Medicaid MCOs conduct a range of care coordination activities for enrollees, including chronic disease management; community health workers, peer support specialists, and health coaches; individualized care plans; and home visits. These approaches could be tailored toward supporting PrEP users in adherence and receiving clinical services, potentially via PrEP navigators.[145] For example, MCOs could work with public health agencies to develop models for supporting PrEP navigation counselors at the plan or provider level.
- Non-Emergency Medical Transportation (NEMT) Benefit: Non-emergency medical transportation is a Medicaid benefit that covers transportation to non-emergency, Medicaid-covered care. By federal regulation, state Medicaid plans must "[s]pecify that the Medicaid agency will ensure necessary transportation for beneficiaries to and from providers; and [d]escribe the methods that the agency will use to meet this requirement."[146] States have considerable latitude in how they implement this requirement, and several states have implemented waivers of the requirement for certain categories of beneficiaries. Stakeholders could review their respective states' NEMT benefits to determine what, if any, transportation resources are available to PrEP-eligible enrollees and include information about the availability of free transportation in PrEP outreach materials.

In addition to these specific benefits, funding models such as PCMHs, Medicaid health homes and ACOs could provide care coordination services to help support PrEP users in adhering to the full PrEP intervention.

Engaging pharmacists to support patients and providers

Increasing pharmacist engagement in various elements of PrEP delivery could help improve patient access and engagement. A recent synthesis of evidence on models for PrEP delivery noted several benefits of pharmacy engagement in PrEP, including the possibility of evening and weekend hours (not always available at providers' office), and pharmacists' ability to review and respond to refill gaps to address nonadherence.[147]

In some states, Medicaid reimburses pharmacists for enhanced medication therapy management, or MTM, services.[148] For example, Mississippi Medicaid's "Pharmacy Disease Management" program reimburses pharmacists for counseling enrollees with a range of diseases including diabetes, asthma, and hyperlipidemia.[149] States with a Medication Therapy Management benefit in their Medicaid programs could explore the possibility of reimbursing pharmacists for providing enhanced counseling and reminders for patients using PrEP.[150]

In addition to engaging patients, an MTM benefit could reimburse for pharmacist engagement with prescribers. For example, a pharmacist who notes that a patient didn't pick up her PrEP prescription could reach out to the prescriber to flag the issue.[151] Conversely, a pharmacist who notices that a patient has multiple refills on their PrEP medication could reach out to the prescriber to ensure that there is a mechanism for the patient to receive required STI, HIV, and other screenings as needed each quarter.[152]

Some pharmacists may be able to conduct HIV testing[153] and possibly collect specimens and forward to a laboratory for other PrEP-related tests (e.g. STI tests with patients self-swabbing). In states that allow advanced pharmacist practice or collaborative practice agreements with clinical practices, pharmacists may be able to actually prescribe PrEP *and* offer clinical services, offering patients the full range of PrEP services at one site. For example, pharmacists at Kelley-Ross Pharmacy in Seattle can prescribe PrEP and offer the full range of CDC-recommended clinical services, receiving Medicaid reimbursement from the Medicaid MCOs with which they contract.[154]

Linking providers to CBOs to support comprehensive care for patients

Providers can partner with community-based organizations to reduce barriers for patients and facilitate provider provision of PrEP, either by offering PrEP navigation or other services like medication adherence support.

For example, clinicians at Open Arms Health Care Center in Jackson, Miss., provide PrEP. Open Arms is affiliated with My Brother's Keeper, a CBO with satellite sites in Hattiesburg and near the Coast. Patient can go to My Brother's Keeper for rapid HIV tests and bloodwork, combined with a telehealth visit with a provider at Open Arms. This reduces transportation time and costs for patients.[155]

At the Medical University of South Carolina (MUSC), the Department of Family Medicine partners with Palmetto Community Care (formerly Low Country AIDS Services) in the provision of PrEP.[156] Palmetto Community Care refers patients to MUSC, where providers can conduct initial assessments and prescribe PrEP. Patients can

then return to PCC for regular labwork, the results of which are shared with the prescribing provider at MUSC. This relationship makes labwork and PrEP adherence support more accessible for patients, while relieving the primary care clinic of some of the work of ongoing monitoring.[157]

Stakeholders should determine whether these relationships exist or could be fostered. To the extent possible, if CBOs are staffed in a way that makes them eligible Medicaid providers, they could be reimbursed for services offered. Non-clinical CBOs could attempt to develop contractual relationships (or MOUs) with state Medicaid agencies or MCOs to help support the provision of services.

NMAC's HIV and PrEP Navigation Program

NMAC's "Linking Communities to Care through HIV and PrEP Navigation" provides capacity building for non-clinical CBOs and health care organizations to offer PrEP and HIV care navigation services.[188] The program focuses on recruitment, linkage, and retention for people of color, focusing on communities most affected by HIV risk. Online resources include a landscape assessment on HIV and PrEP Navigation as well as a guide on motivational interviewing for HIV and PrEP.

Further considerations

This section addresses additional considerations for engaging patients and providers in PrEP medication and care through the Medicaid program:

- State and MCO cultural competency requirements as a potential nexus for efforts to address various forms of stigma surrounding PrEP;
- The importance of recognizing Medicaid "churn" and guiding consumers through eligibility changes while continuing to adhere to the PrEP intervention suite;
- Mechanisms for coordinating PrEP for people returning to the community from the corrections system; and
- Adolescent minors and privacy within Medicaid.

It closes with a discussion of addressing PrEP for people who use drugs, particularly in light of heightened attention to the opioid epidemic.

Cultural competency in Medicaid programs

Federal regulations require state Medicaid programs to develop methods to promote culturally competent services:

> **Access and Cultural Considerations.** The State must have methods to promote access and delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These methods must ensure that beneficiaries have access to covered services that are delivered in a manner that meets their unique needs.[158]

Further, regulations require all Medicaid MCOs – as well as limited benefit Medicaid managed care plans called Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs) – to participate in these state activities:

> Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.[159]

States could identify existing Medicaid and MCO activities to promote cultural competency, and explore opportunities to incorporate information related to PrEP, as well as to broader education to address stigma and bias related to race, sexual orientation, and gender identity.

Assisting patients with PrEP adherence through enrollment changes

An individual's Medicaid status is not static. For example, people may lose eligibility for Medicaid because of increases in income, becoming eligible instead for subsidized coverage through state-level marketplaces under the Affordable Care Act. In non-Medicaid expansion states, people who are eligible for Medicaid under very low income thresholds could lose eligibility at a slightly higher income level and become uninsured. In all states, people may lose eligibility for administrative reasons such as failing to complete paperwork in a timely fashion.

Churning can have serious impacts on access to care. A recent study of 2015 data in three states found that almost 1 in 4 low-income adults reported a change in coverage during the prior year, with half of those reporting a *gap* in coverage.[160] The study found significant disruptions of care for "churners," including a third reporting skipping doses or stopping taking prescribed medications[161] While not PrEP-specific, the study's findings raise concerns regarding PrEP adherence through coverage changes.

Providers whose PrEP patients lose Medicaid eligibility should be prepared to help navigate continuous access to PrEP medication and clinical services, whether under new insurance or through patient assistance programs and other funding streams. For example, one interviewee, a PrEP Navigator at a public health STD clinic, noted that she has helped people sign up for the Gilead patient assistance program as a stopgap when faced with interruptions in public or private insurance coverage.[162] Medicaid agencies could consider collaborating with public health agencies to develop resource guides that educate providers and patients on other sources of PrEP coverage if eligibility changes.

It is also important to note that in states with multiple Medicaid MCOs, beneficiaries could retain coverage but switch plans. Alignment across MCOs, including utilization management approaches and coverage policies for STI screening and other clinical services, would help smooth the transition for patients using PrEP.

Facilitating PrEP access for Medicaid-eligible people leaving the corrections system

Some people returning to the community after being incarcerated may be candidates for PrEP. Most states suspend, rather than terminate, Medicaid enrollment for individuals while they are incarcerated, in part to facilitate restarting coverage upon release.[163] The majority of states also have initiatives to facilitate Medicaid enrollment before release.[164] As part of the pre-release process, states can identify patients with heightened health or social needs. For example, Louisiana's state Medicaid agency begins planning nine months before release, and the process includes identification of "high needs" people such as those with serious mental illness, substance use disorder, or multiple morbidities.[165] States could explore whether Medicaid pre-release coordination processes in their state could address PrEP eligibility and include appropriate education and referrals.

Privacy for adolescent minors and other PrEP users in State Medicaid programs

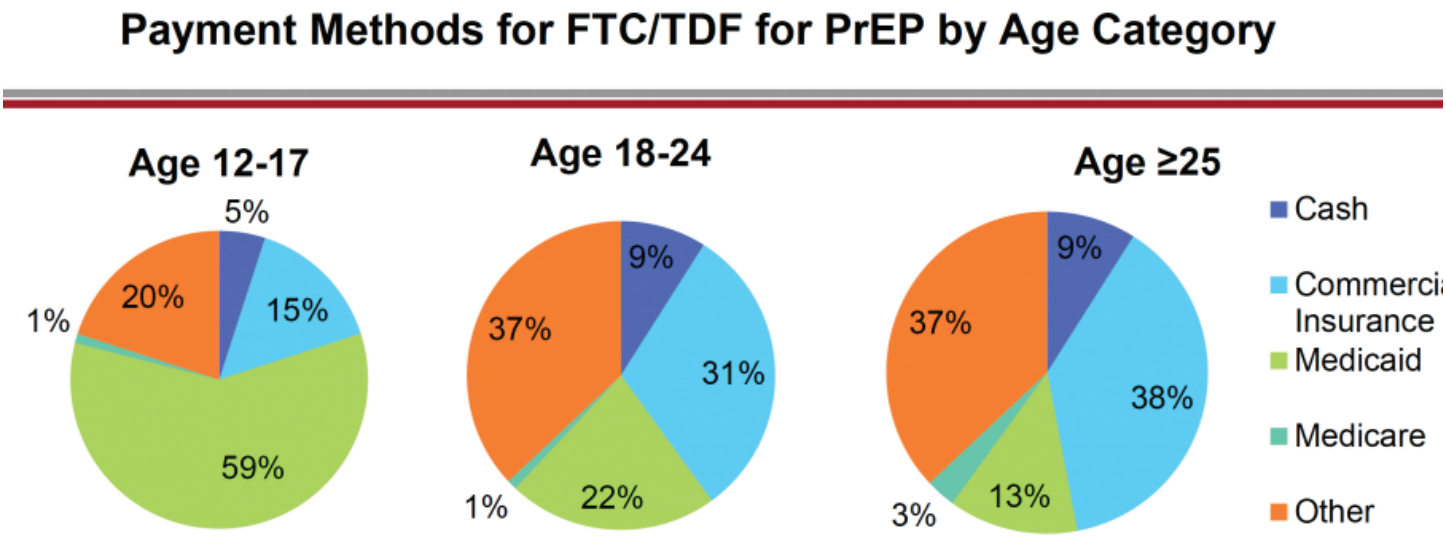
While Truvada has been used off-label for PrEP in adolescents prior to this year, FDA recently formally extended the drug's PrEP indication to adolescents weighing at least 35 kg (approx. 77 pounds).[166] A recently published study surveying a subset of members of the Society of Adolescent Health and Medicine found that a vast majority of respondents (93.2 percent) had heard of PrEP, and that 35.2 percent had prescribed it. However, overall young people are not accessing PrEP in proportion to the HIV risk experienced in this age group. Data presented by Gilead at the 2018 International AIDS Conference showed that 15 percent of people who had ever used Truvada were under age 25; only 1.5 percent were teenagers (and over 83 percent of the teenagers were girls).[167]

Among 12-17 year-olds, the data reflected that Medicaid was the most significant payer[168]:

PrEP as a Conduit to Medicaid or Other Insurance Coverage

To maximize Medicaid support of PrEP medication and clinical services, both clinical PrEP providers and non-clinical CBOs engaged in PrEP should engage in routine insurance screening and/or referral. Patients are not always aware of their eligibility for Medicaid, and these programs could help identify the eligible unenrolled. Insurance assistance could also help PrEP users navigate Medicaid administrative requirements to avoid gaps in coverage and access. Two interviewees noted that their intake processes for PrEP patients include counseling on Medicaid and other benefit eligibility as well as assistance with enrollment.[189,190]

A further reason for robust insurance assistance is that linking PrEP-eligible people to Medicaid or other insurance improves access to a broad range of services, including mental health and substance use disorder treatment services, further improving overall health and reducing HIV risk factors. In addition, identifying Medicaid-eligible people can help conserve funding in state and local PrEP assistance programs, such as those offered by Washington State,[191] New York State,[192] and Washington DC.[193]



Benefit-wise, since PrEP medication is approved for adolescents, Medicaid and CHIP programs should be expected to cover PrEP medication and clinical services for adolescents on the same terms as for adults. However, adolescent use can raise heightened questions about privacy. Federal law requires state Medicaid programs to have a process for confirming that beneficiaries in fact received the services billed. To comply with this requirement, some states send "explanation of benefit" (EOB) notices to beneficiaries after services are delivered, though this approach is not required. In addition, federal law requires Medicaid MCOs to send written notices of denials, or partial denials, of requests.

In a related issue for adolescents that is not Medicaid-specific, only some states' laws explicitly permit minors to independently consent to PrEP. The CDC's compilation of minor consent laws regarding HIV and STI services offers a starting point for state-level identification of any potential barriers for minor consent.[169]

State Medicaid agencies can identify how their EOB and privacy policies would apply to adolescents and other enrollees using PrEP and related services, and whether any suppression policy extends to denial notices. Pediatricians, adolescent health providers, and others who may offer PrEP or discuss it with adolescents should be made aware of what Medicaid privacy protections apply in their respective states.

PrEP and Substance Use

The key randomized trial of PrEP use among people who inject drugs, or PWID, found a reduction in HIV incidence of 49.8 percent compared to the placebo arm; for patient with high levels of adherence, the risk reduction was 73.5 percent.[170]

PWID may be willing to use PrEP but experience a range of barriers. Some studies have found extremely low rates of PrEP awareness among PWID in the US.[171] However, a number of studies have found fairly high *willingness* to use PrEP once information is shared. For example, in a study of PWID using a mobile syringe exchange service in Camden, NJ, 88.9 percent of women and 71.0 percent of men expressed willingness to use PrEP.[172] However, respondents also reported multiple barriers to PrEP use, including "feeling embarrassed (45.0%) or anxious (51.6%) about taking PrEP, nondisclosure to partners (51.4%), limited engagement with health care providers where PrEP might be provided (43.8%), and lacking health insurance (32.9%)."[173]

Meanwhile, substance use treatment providers may experience their own barriers to engaging in PrEP provision. For example, one study identified multiple barriers to PrEP provision among substance use treatment providers in six New York City outpatient programs.[174] At the time (2014), very few study respondents were aware of PrEP. Response was generally positive, but provider concerns about implementation included lack of medical staff to prescribe and monitor PrEP, questions about cost and reimbursement (including via Medicaid), and the need for training to help providers educate patients.[175] In addition, as noted by one interviewee, adherence concerns have historically led providers to hesitate to prescribe medication, such as ART or HCV treatment, to people who use drugs.[176]

Stakeholders could take a number of steps to explore the benefits and challenges of trying to improve access to PrEP medication and clinical services for people who inject drugs. A number of complex issues should be considered.[177]

- What do the epidemiologic data show in the state regarding people at high risk of HIV based on injection drug use? What about use of other drugs, which may impact sexual risk? What is the overlap of this group with Medicaid eligibility in the state?
- Are substance use treatment providers, including those offering medication-assisted treatment for opioid use, offering PrEP for prevention of sexual acquisition or of injection transmission in the case of relapse of injection drug use? Can or should these services be bundled with other SUD services?
- Are adequate syringe exchange programs (SEPs) currently in place? SEPs are highly effective at preventing the transmission of HIV by injection, as well as other viruses and bacteria. If an SEP is already providing high levels of HIV protection, what added level of risk protection, such as against sexual risk, would PrEP services offer? Are there other potential outreach approaches to reach people at risk of HIV who are *not* clients of SEPs? Could PrEP be instituted as an interim approach while SEPs are being established in the wake of significant HIV events in injection drug use, like the outbreak in Scott County, Indiana?
- How does injection drug use or the use of other drugs overlap with sexual risk factors for HIV? Among people with multiple risk factors, how many identify (internally or to their providers) as people who inject or use drugs? Would programs targeting PWID reach these populations?
- What is the ROI for PrEP for PWID? A 2016 study modeled evaluated the cost-effectiveness of providing adult U.S. PWID with PrEP, PrEP with frequent screening, and PrEP with ART for those who seroconvert.[178] The analysis found that the third scenario, PrEP + screening + ART, would offer the best outcome, averting 26,700 new infections.[179] However, it would cost $253,000 per QALY, compared to $4500-$34,000 per QALY in an SEP.[180]

Multiple interviewees noted that the current public health and political concern about the opioid epidemic is driving resources toward helping people who use drugs, including injection drugs. Therefore, to the extent stakeholders are interested in expanding PrEP access among people who inject or otherwise use drugs, they could identify opportunities for incorporating PrEP within and beyond the Medicaid program.

Conclusion

Scaling up the full PrEP intervention suite will require extensive patient and provider education and support efforts. As generic PrEP drugs and, potentially, long-acting injectables become available, the role of biomedical prevention will be even more important. The Medicaid program offers important opportunities to reach providers, as well as many of the patients who could most benefit from PrEP. The approaches outlined in this paper can serve as a starting point to identify next steps to seize these opportunities at the state level.

Appendix 1: Project Steering Committee

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Endnotes

1 Siegler AJ, et al., The prevalence of pre-exposure prophylaxis use and the pre-exposure prophylaxis to-need ratio in the fourth quarter of 2017, United States, Annals of Epidemiology (2018), https://doi.org/10.1016/j.annepidem.2018.06.005

2 CDC, "HIV prevention pill not reaching most Americans who could benefit – especially people of color" (Mar. 2018). www.cdc.gov/nchhstp/newsroom/2018/croi-2018-PrEP-press-release.html

3 See, e.g., California HIV/AIDS Research Program, "Addressing PrEP Disparities Among Young Gay and Bisexual Men in California" (Sep. 2016). https://apla-health.org/wp-content/uploads/2016/09/APLA_PrEP_FullReport_WEB.pdf

4 Goldstein et al., "Being PrEPared — Preexposure Prophylaxis and HIV Disparities." New England Journal of Medicine (Sept. 19, 2018). www.nejm.org/doi/full/10.1056/NEJMp1804306?query=TOC

5 Smith et al., "Estimates of adults with indications for HIV pre-exposure prophylaxis by jurisdiction, transmission risk group, and race/ethnicity, United States, 2015" Annals of Epidemiology xxx (2018) 1-8.

6 Huang et al., "HIV Preexposure Prophylaxis, by Race and Ethnicity — United States, 2014–2016." MMWR Morb Mortal Wkly Rep. 2018 Oct 19; 67(41): 1147–1150.

7 AIDSVU, "Deeper Look: PrEP." https://aidsvu.org/resources/deeper-look-prep/

8 Spinelli et al., "Provider Adherence to Pre-exposure Prophylaxis Monitoring Guidelines in a Large Primary Care Network" Open Forum Infectious Diseases, Volume 5, Issue 6, 1 June 2018, ofy099, https://doi.org/10.1093/ofid/ofy099

9 *Id.*

10 CDC, "PrEP" (Updated Aug. 23, 2018). www.cdc.gov/hiv/basics/prep.html

11 ANDA Approval Letter from FDA to Teva Pharmaceuticals USA, Inc. (June 8, 2017). www.accessdata.fda.gov/drugsatfda_docs/appletter/2017/090894Orig1s000ltr.pdf

12 *Id.*

13 CDC, "Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update: A Clinical Practice Guideline." " (Published online Mar. 2018). https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf

14 Nunn et al., "Defining the HIV pre-exposure prophylaxis care continuum." AIDS. 2017 Mar 13;31(5):731-734. doi: 10.1097/QAD.0000000ubach0000001385.

15 Strauss et al., "Exploring Patterns of Awareness and Use of HIV Pre-Exposure Prophylaxis Among Young Men Who Have Sex with Men." AIDS Behav. 2017 May;21(5):1288-1298. doi: 10.1007/s10461-016-1480-0.

16 Interview with Liz Hacker, October 5, 2018.

17 CDC, "HIV Among Youth." https://www.cdc.gov/hiv/group/age/youth/index.html.

18 Strauss et al., "Exploring Patterns of Awareness and Use of HIV Pre-Exposure Prophylaxis Among Young Men Who Have Sex with Men." AIDS Behav. 2017 May;21(5):1288-1298. doi: 10.1007/s10461-016-1480-0.

19 CDC, "HIV and Gay and Bisexual Men." https://www.cdc.gov/hiv/group/msm/index.html

20 CDC, "HIV Among Transgender People." https://www.cdc.gov/hiv/group/gender/transgender/index.html

21 Garnett et al., "Limited awareness of pre-exposure prophylaxis among black men who have sex with men and transgender women in New York City." AIDS Care. 2018 Jan;30(1):9-17. doi: 10.1080/09540121.2017.1363364. Epub 2017 Aug 9.

22 CDC, "HIV Among Women." https://www.cdc.gov/hiv/group/gender/women/index.html

23 Huang et al., "HIV Preexposure Prophylaxis, by Race and Ethnicity — United States, 2014–2016." MMWR Morb Mortal Wkly Rep. 2018 Oct 19; 67(41): 1147–1150.

24 Auerbach et al., "Knowledge, Attitudes, and Likelihood of Pre-Exposure Prophylaxis (PrEP) Use Among US Women at Risk of Acquiring HIV." AIDS Patient Care STDS. 2015 Feb 1; 29(2): 102–110.

25 Wood et al., "Young Transgender Women's Attitudes Toward HIV Pre-Exposure Prophylaxis." J Adolesc Health. (2017) May; 60(5): 549–555.

26 Auerbach et al., "Knowledge, Attitudes, and Likelihood of Pre-Exposure Prophylaxis (PrEP) Use Among US Women at Risk of Acquiring HIV." AIDS Patient Care STDS. 2015 Feb 1; 29(2): 102–110.

27 Interview with Kristin Keglovitz-Baker and Chad Hendry, September 27, 2018.

28 Data.Medicaid.Gov, "National Average Drug Acquisition Cost" Database. https://data.medicaid.gov/Drug-Pricing-and-Payment/NADAC-National-Average-Drug-Acquisition-Cost-/a4y5-998d

29 Guerrero, "Myth Busted! PrEP Does Not Lower HRT Levels In Trans Women." Plus (July 30, 2018). https://www.hivplusmag.com/prevention/2018/7/30/myth-busted-prep-does-not-lower-hrt-trans-women

30 Hiransuthikul et al., "Drug-drug interactions between the use of feminizing hormone therapy and pre-exposure prophylaxis among transgender women: The iFACT study." Presented at the 22nd International AIDS Conference (2018). https://programme.aids2018.org//PAGMaterial/eposters/13177.pdf

31 See also Hubach et al., "Barriers to and Adoption of Pre-Exposure Prophylaxis for the Prevention of HIV Among Men Who Have Sex with Men (MSM) in a Relatively Rural State" AIDS Education and Prevention, 29(4), 315–329, 2017.

32 Interview with Liz Hacker, October 5, 2018.

33 Hubach et al., "Barriers to and Adoption of Pre-Exposure Prophylaxis for the Prevention of HIV Among Men Who Have Sex with Men (MSM) in a Relatively Rural State" AIDS Education and Prevention, 29(4), 315–329, 2017.

34 Interview with Liz Hacker, October 5, 2018.

35 Seidman et al., "Family planning providers' role in offering PrEP to women." Contraception 97 (2018) 467–470.

36 Maloney et al., "Culturally Competent Sexual Healthcare as a Prerequisite for Obtaining Preexposure Prophylaxis: Findings from a Qualitative Study." LGBT Health (2017); Volume 4, Number 7.

37 Cahill et al., "Stigma, medical mistrust, and perceived racism may affect PrEP awareness and uptake in black compared to white gay and bisexual men in Jackson, Mississippi and Boston, Massachusetts." AIDS Care. 2017 Nov; 29(11): 1351–1358.

38 Eaton et al., "Stigma and Conspiracy Beliefs Related to Pre-exposure Prophylaxis (PrEP) and Interest in Using PrEP Among Black and White Men and Transgender Women Who Have Sex with Men." AIDS Behav. 2017 May; 21(5): 1236–1246.

39 Calabrese et al., "HIV Pre-Exposure Prophylaxis Stigma as a Multidimensional Barrier to Uptake Among Women Who Attend Planned Parenthood." JAIDS: September 1, 2018 - Volume 79 - Issue 1 - p 46–53doi: 10.1097/QAI.0000000000001762.

40 *Id.*

41 Blackstock et al., "A Cross-Sectional Online Survey of HIV Pre-Exposure Prophylaxis Adoption Among Primary Care Physicians" J Gen Intern Med (2016) 32(1):62–70.

42 Blumenthal et al., "Knowledge is Power! Increased Provider Knowledge Scores regarding Pre-exposure Prophylaxis (PrEP) are Associated with Higher Rates of PrEP Prescription and Future Intent to Prescribe PrEP." AIDS Behav. 2015 May ; 19(5): 802–810. doi:10.1007/s10461-015-0996-z.

43 Petroll et al., "PrEP Awareness, Familiarity, Comfort, and Prescribing Experience among US Primary Care Providers and HIV Specialists." AIDS Behav. 2017 May ; 21(5): 1256–1267. doi:10.1007/s10461-016-1625-1.

44 Clement et al., "An educational initiative in response to identified PrEP prescribing needs among PCPs in the Southern U.S.," AIDS Care, 30:5,650-655, DOI: 10.1080/09540121.2017.1384534.

45 Petroll et al., "PrEP Awareness, Familiarity, Comfort, and Prescribing Experience among US Primary Care Providers and HIV Specialists." AIDS Behav. 2017 May ; 21(5): 1256–1267. doi:10.1007/s10461-016-1625-1.

46 Interview with Donna Sweet, August 16, 2018.

47 *Id.*

48 Interview with Erin Loubier, Juan Carlos Loubriel, and Megan Coleman, August 7, 2018.

49 Interview with Sarah Calabrese, August 21, 2018.

50 Calabrese, Krakower, and Mayer, "Integrating HIV Preexposure Prophylaxis (PrEP) Into Routine Preventive Health Care to Avoid Exacerbating Disparities." American Journal of Public Health December 2017, Vol 107, No. 12.

51 Interview with Doug Krakower, August 9, 2018.

52 Blumenthal et al., "Knowledge is Power! Increased Provider Knowledge Scores regarding Pre-exposure Prophylaxis (PrEP) are Associated with Higher Rates of PrEP Prescription and Future Intent to Prescribe PrEP." AIDS Behav. 2015 May ; 19(5): 802–810. doi:10.1007/s10461-015-0996-z.

53 Wood et al., "Knowledge, Practices, and Barriers to HIV Preexposure Prophylaxis Prescribing Among Washington State Medical Providers." Sexually Transmitted Diseases (July 2018) Volume 45, Number 7.

54 Blackstock et al., "A Cross-Sectional Online Survey of HIV Pre-Exposure Prophylaxis Adoption Among Primary Care Physicians" J Gen Intern Med (2016) 32(1):62–70.

55 Calabrese et al., "Putting PrEP into Practice: Lessons Learned from Early-Adopting U.S. Providers' Firsthand Experiences Providing HIV Pre-Exposure Prophylaxis and Associated Care. PLoS ONE (2016) 11(6): e0157324. doi:10.1371/journal.pone.0157324

56 See, e.g., Wood et al., "Knowledge, Practices, and Barriers to HIV Preexposure Prophylaxis Prescribing Among Washington State Medical Providers." Sexually Transmitted Diseases (July 2018) Volume 45, Number 7.

57 Krakower et al., "HIV Providers' Perceived Barriers and Facilitators to Implementing Pre-Exposure Prophylaxis in Care Settings: A Qualitative Study." AIDS Behav. 2014 September ; 18(9): 1712–1721. doi:10.1007/s10461-014-0839-3

58 Interview with Gretchen Weiss, August 17, 2018.

59 Hoover et al., "Human Immunodeficiency Virus Prevention With Preexposure Prophylaxis in Sexually Transmitted Disease Clinics." Sexually Transmitted Diseases Volume 43, Number 5, May 2016.

60 See, e.g., Interview with Doug Krakower, August 9, 2018; interview with Donna Sweet, August 16, 2018.

61 Interview with John Carlo, August 6, 2018.

62 Calabrese et al., "A Closer Look at Racism and Heterosexism in Medical Students' Clinical Decision-Making Related to HIV Pre-Exposure Prophylaxis (PrEP): Implications for PrEP Education." AIDS and Behavior (2018) 22:1122–1138. https://doi.org/10.1007/s10461-017-1979-z

63 Calabrese et al., "The Impact of Patient Race on Clinical Decisions Related to Prescribing HIV Pre-Exposure Prophylaxis (PrEP): Assumptions About Sexual Risk Compensation and Implications for Access." AIDS Behav. (2014) February; 18(2): 226–240. doi:10.1007/s10461-013-0675-x.

64 Raifman et al., "Healthcare Provider Contact and Pre-exposure Prophylaxis in Baltimore Men Who Have Sex With Men" Am J Prev Med. 2017 January; 52(1): 55–63. doi:10.1016/j.amepre.2016.07.031.

65 Hubach et al., "Barriers to and Adoption of Pre-Exposure Prophylaxis for the Prevention of HIV Among Men Who Have Sex with Men (MSM) in a Relatively Rural State" AIDS Education and Prevention, 29(4), 315–329, 2017.

66 See, e.g., District of Columbia Department of Health, "Explore your Options: PrEP." https://doitrightdc.com/prep/prep-locator/

67 North Carolina AIDS Education and Training Center, "Consumers Interested in or Currently Taking PrEP." https://www.med.unc.edu/ncaidstraining/clinician-resources/prep/prep-for-consumers/

68 CDC, "Prescribe HIV Prevention." https://www.cdc.gov/actagainstaids/campaigns/prescribe-hiv-prevention/index.html

69 D.C. Department of Health, "PrEP Handbook: PrEP is DC's Key HIV Prevention Practice." https://doh.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/DC%20Providers%20PrEP%20Handbook.pdf

70 Interview with Melody Wilkinson, August 22, 2018.

71 Interview with Kristin Keglovitz-Baker and Chad Hendry, September 27, 2018.

72 See, e.g., SIECUS, "PrEP Education for Youth-Serving Primary Care Providers Toolkit: Clinical Tools Section 1.7: Taking A Sexual History" (2018) https://siecus.org/wp-content/uploads/2018/07/1.7-Taking-A-Sexual-History.pdf

73 Decker, "Academic detailing as an intervention to increase PrEP knowledge and best prescribing practices among providers in San Francisco" (July 20, 2017). www.nastad.org/sites/default/files/Mega-Meeting-Slides/opportunities_to_engage_clinical_providers_-_alyson_decker.pdf

74 AcademyHealth Interview with Deann Gruber, May 23, 2018.

75 AcademyHealth interview with Lyn Stevens, June 5, 2018.

76 Interview with Player and Diaz, August 28, 2018.

77 *Id.*

78 Interview with Sarah Calabrese, August 21, 2018.

79 Interview with Melody Wilkinson, August 22, 2018.

80 New York State Department of Health AIDS Institute, "Clinical Education Initiative" www.surveymonkey.com/r/BG38MH5.

81 Interview with Sarah Calabrese, August 21, 2018.

82 Interview with Liz Hacker, October 5, 2018.

83 Liu et al., "Randomized Controlled Trial of a Mobile Health Intervention to Promote Retention and Adherence to Preexposure Prophylaxis Among Young People at Risk for Human Immunodeficiency Virus: The EPIC Study," Clinical Infectious Diseases (2018). https://doi.org/10.1093/cid/ciy810

84 Email from Pedro Serrano, Oct. 26, 2018.

85 Interview with Player and Diaz, August 28, 2018.

86 Interview with Bellinda Schoof, August 29, 2018.

87 CDC, "Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update – Clinical Providers' Supplement" (Published online Mar. 2018). www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-provider-supplement-2017.pdf

88 The Stigma Project, www.ispreprightforme.org.

89 Amico et al., "Integrated Next Step Counseling (iNSC) for Sexual Health and PrEP Use Among Young Men Who Have Sex with Men: Implementation and Observations from ATN110/113." AIDS Behav (2018). https://doi.org/10.1007/s10461-018-2291-2

90 UCSF Clinical Consultation Center, "PrEP: Pre-Exposure Prophylaxis" (2018). Available at https://nccc.ucsf.edu/clinician-consultation/prep-pre-exposure-prophylaxis/

91 AETC National Coordinating Resource Center, "Directory of AIDS Education and Training Centers" (2018). https://aidsetc.org/directory

92 Interview with Erin Loubier, Juan Carlos Loubriel, and Megan Coleman, August 7, 2018.

93 Interview with Douglas Krakower, August 8, 2018.

94 Interview with Diva Ahuja, August 9, 2018.

95 Interview with Stephen Cha, August 6, 2018; www.medicaid.gov/federal-policy-Guidance/index.html

96 CMS, "Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries" (Dec. 2016). www.medicaid.gov/federal-policy-guidance/downloads/cib120116.pdf

97 CMS, "Medicaid.gov: Substance Use Disorder Tools & Resources." www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/tools-and-resources/index.html

98 AcademyHealth survey of MMDN, October 2018.

99 *Id.*

100 California Department of Health Care Services, "DUR: Educational Articles" http://files.medi-cal.ca.gov/pubsdoco/dur/edarticles.asp

101 New York State Department of Health, "DOH Medicaid Update." www.health.ny.gov/health_care/medicaid/program/update/main.htm

102 AcademyHealth survey of MMDN, October 2018.

103 Interview with Doug Wirth, September 17, 2018.

104 *Id.*

105 Interview with David Rzeszutko, August 14, 2018.

106 AcademyHealth survey of MMDN network, October 2018.

107 Interview with Stephen Cha, August 6, 2018.

108 National Medical Association, "About Us." https://www.nmanet.org/page/About_Us

109 National Hispanic Medical Association, "About NHMA." http://www.nhmamd.org/about/about-nhma/

110 American College of Physicians, "About ACP." https://www.acponline.org/about-acp

111 AMA, "AMA Urges More Physician Education on Use of Once-A-Day HIV Prevention" (June 2016). www.ama-assn.org/ama-urges-more-physician-education-use-once-day-hiv-prevention

112 *Id.*

113 AMA, "Member Groups (Sections)." www.ama-assn.org/about/member-groups-sections

114 AMA, "AMA Federation Directory." https://federationdirectory.ama-assn.org/federations

115 AAFP, "Family Medicine Facts." www.aafp.org/about/the-aafp/family-medicine-facts.html

116 AAFP, "Table 1: 2018 AAFP Membership Category" www.aafp.org/about/the-aafp/family-medicine-facts/table-1.html

117 AAFP, "Prevention and Control of Sexually Transmitted and Blood Borne Infections" (2016). www.aafp.org/about/policies/all/prevention-control.html

118 Interview with Bellinda Schoof, August 29, 2018.

119 Interview with Melody Wilkinson, August 22, 2018.

120 AAFP, "Browse Directory." https://my.aanp.org/Directories/BrowseBy.aspx

121 Interview with Gretchen Weiss, August 17, 2018.

122 Interview with Leighton Ku, September 5, 2018.

123 For example, the State-University Partnership Learning Network (SUPLN) fosters collaboration between state governments and state university research centers to conduct research on the Medicaid program. https://www.academyhealth.org/SUPLN.

124 Interview with Leighton Ku, September 5, 2018.

125 *Id.*

126 Interview with Doug Wirth, September 17, 2018.

127 To distinguish between PrEP and post-exposure prophylaxis, which involves 28 days of medication.

128 Laufer et al., "Vital Signs: Increased Medicaid Prescriptions for Preexposure Prophylaxis Against HIV infection — New York, 2012–2015." MMWR November 27, 2015 / 64(46);1296-1301. www.cdc.gov/mmwr/preview/mmwrhtml/mm6446a5.htm

129 California HIV/AIDS Policy Research Centers. Examining PrEP Uptake among Medi-Cal Beneficiaries in California: Differences by Age, Gender, Race/Ethnicity and Geographic Region (Feb. 2018). http://www.californiaaidsresearch.org/files/PrEP_Brief_2.8.18.pdf

130 Smith et al., "Estimates of adults with indications for HIV pre-exposure prophylaxis by jurisdiction, transmission risk group, and race/ethnicity, United States, 2015" Annals of Epidemiology xxx (2018) 1-8.

131 Email from Pedro Serrano, Oct. 26, 2018.

132 Interview with Leighton Ku, September 5, 2018.

133 NASTAD, "Modernizing Programs to Collect Sexual Orientation and Gender Identity Data." www.nastad.org/sites/default/files/sogi.issue_.brief_.final_.pdf

134 Interview with Doug Krakower, August 8, 2018.

135 Interview with Leighton Ku, September 5, 2018.

136 AcademyHealth Interview with Michigan officials, May 24, 2018.

137 Center for Connected Health Policy, "50 State Scan of Telehealth Reimbursement Laws and Medicaid Policies – Factsheet" (2018). www.cchpca.org/sites/default/files/resources/50%20State%20Factsheet%20Spring%202018%20FINAL.pdf

138 *Id.*

139 Kaiser Family Foundation, Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans" (Mar. 2018). www.kff.org/report-section/medicaid-managed-care-plans-and-access-to-care-provider-networks-and-access-to-care/

140 Peter Wehrwein, "Q&A: A Conversation with Henry DePhillips, MD: The Doctor in the Teladoc House" (April 2017). www.managedcaremag.com/archives/2017/4/conversation-henry-dephillips-md-doctor-teladoc-house

141 AcademyHealth interview with Lyn Stevens, June 5, 2018.

142 AcademyHealth Interview with Deann Gruber, May 23, 2018; www.louisianahealthhub.org/teleprep

143 Interview with Jason Farley, August 9, 2018.

144 NASTAD, "Financing HIV Prevention Services: Collaboration and Innovation between Public Health and Medicaid Agencies; Case Study: Rhode Island" (Feb. 2016). www.nastad.org/sites/default/files/resources/docs/NASTAD-HIV-Prevention-Rhode-Island-Case-Study.pdf

145 Interview with Erin Loubier, Juan Carlos Loubriel, and Megan Coleman, August 7, 2018.

146 42 CFR 431.53 - Assurance of transportation.

147 Mayer et al., "Evolving Models and Ongoing Challenges for HIV Preexposure Prophylaxis Implementation in the United States" J Acquir Immune Defic Syndr (2018);77:119–127.

148 National Conference of State Legislatures, "Medication Therapy Management: Pharmaceutical Safety and Savings" (Updated Oct. 2016). http://www.ncsl.org/research/health/medication-therapy-management.aspx

149 Mississippi Division of Medicaid, "Mississippi Medicaid Provider Reference Guide: Part 214: Pharmacy Services" (2014). https://medicaid.ms.gov/wp-content/uploads/2014/01/Provider-Reference-Guide-214.pdf

150 Interview with Elyse Tung, September 7, 2018.

151 *Id.*

152 *Id.*

153 Interview with Laura Beauchamps, August 16, 2018.

154 Interview with Elyse Tung, September 7, 2018.

155 Interview with Laura Beauchamps, August 16, 2018.

156 Interview with Player and Diaz, August 28, 2018.

157 *Id.*

158 42 CFR § 440.262 Access and cultural considerations.

159 42 CFR 438.206 - Availability of services.

160 Sommers et al., "Insurance Churning Rates For Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful For Many." Health Affairs 35, No. 10 (2016).

161 *Id.*

162 Interview with Liz Hacker, October 5, 2018.

163 Kaiser Family Foundation, "Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018" (Oct. 2017). http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018

164 *Id.*

165 *Id.*

166 Letter from FDA to Gilead (May 15, 2018). www.accessdata.fda.gov/drugsatfda_docs/appletter/2018/021752Orig1s055ltr.pdf

167 Ryan, "Just 15% of Those Who've Started PrEP Are Younger Than 25." Poz (July 30, 2018). www.poz.com/article/just-15-whove-started-prep-younger-25

168 Data from Gilead, reproduced in Ryan, "Just 15% of Those Who've Started PrEP Are Younger Than 25." Poz (July 30, 2018). https://www.poz.com/article/just-15-whove-started-prep-younger-25

169 CDC, "Minors' Consent Laws for HIV and STI Services" (Updated June 2018). www.cdc.gov/hiv/policies/law/states/minors.html

170 Choopanya et al. "Antiretroviral prophylaxis for HIV infection in injecting drug users in Bangkok, Thailand (the Bangkok Tenofovir Study): A randomised, double-blind, placebo-controlled phase 3 trial." Lancet 2013; 381:2083–2090.

171 See, e.g., Stein et al., "Willingness to use HIV pre-exposure prophylaxis among opiate users" AIDS Behav (2014); 18:1694–1700; finding PrEP awareness of 7.4 percent among opioid users entering detox.

172 Roth et al., "An Exploration of Factors Impacting Preexposure Prophylaxis Eligibility and Access Among Syringe Exchange Users." Sexually Transmitted Diseases (April 2018) 45: 4.

173 *Id.*

174 Spector et al.," PrEP in substance abuse treatment: a qualitative study of treatment provider perspectives." Substance Abuse Treatment, Prevention, and Policy (2015) 10:1. www.substanceabusepolicy.com/content/10/1/1

175 *Id.*

176 Interview with Daniel Raymond, October 4, 2018.

177 *Id.*

178 Bernard et al., "Cost-Effectiveness of HIV Preexposure Prophylaxis for People Who Inject Drugs in the United States." Ann Intern Med. ;165:10–19.

179 *Id.*

180 *Id.*

181 See https://grants.nih.gov/grants/guide/rfa-files/rfa-ai-16-031.html

182 Interview with Sarah Calabrese, August 21, 2018; Walsh and Petroll, "Factors Related to Pre-exposure Prophylaxis Prescription by U.S. Primary Care Physicians." Am J Prev Med 2017 Jun;52(6).

183 Chartier et al., "Accessibility and Uptake of Pre-Exposure Prophylaxis for HIV Prevention in the Veterans Health Administration." Fed Pract. 2018 March;35(2):S42-S48.

184 *Id.*

185 California Department of Health Care Services, "Erroneous Treatment Delays and Denials for HIV PrEP and PEP" (Dec. 11, 2017). http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_26539.asp.

186 New York State Department of Health, "Truvada (emtricitabine and tenofovir DF) Medicaid Fee-for-Service." www.health.ny.gov/diseases/aids/general/prep/truvada.htm

187 Interview with Leighton Ku, September 5, 2018.

188 NMAC, HIV and PrEP Navigation Program: Linking Communities to Care through HIV and PrEP Navigation. www.nmac.org/programs/capacity-building/hiv-prep-navigation-program/

189 Interview with Laura Beauchamps, August 16, 2018.

190 Interview with Liz Hacker, October 5, 2018.

191 Washington State Department of Health, "Pre-Exposure Prophylaxis Drug Assistance Program (PrEP DAP)." www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/Prevention/PrEPDAP

192 New York State Department of Health, "PrEP Patient Assistance Program (PrEP-AP)." www.health.ny.gov/diseases/aids/general/prep/prep-ap_provider.htm

193 DC Department of Health, "Pre Exposure Prophylaxis Drug Assistance Program (PrEP DAP)." https://dchealth.dc.gov/DCPrEPDAP

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Leveraging Financing and Coverage Benefits: Medicaid Strategies to Deliver PrEP Intervention Services

Prepared for the CDC, ChangeLab and AcademyHealth as part of the Medicaid Strategies to Implement Comprehensive PrEP Intervention Services project

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Table of Contents

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Introduction

Pre-exposure prophylaxis, or PrEP, is a highly effective HIV prevention intervention that is dramatically underused, with one recent analysis suggesting that fewer than 1 in 10 people with indications for PrEP in the U.S. are receiving it.[1] Use of PrEP is disproportionately low among African American and Latinx people, as well as lower-income populations.[2,3,4] Between 2015 and 2016, an estimated 1.14 million Americans were eligible for PrEP, but only 90,000 PrEP prescriptions were filled; only 1 percent of eligible African Americans and 3 percent of eligible Latinos were using PrEP, compared to 14 percent of eligible Whites.[5] Among those who do use PrEP, evidence indicates that some may not be receiving the full set of PrEP clinical services as recommended by the Centers for Disease Control and Prevention (CDC) – such as HIV screening before initiation and quarterly, multisite STI screenings.[6]

As part of its work to address these challenges, the CDC is supporting a project, led by AcademyHealth and ChangeLab, to identify ways to improve care and delivery of PrEP medication and clinical services to the Medicaid population. Medicaid's role as insurance for low-income Americans – particularly since the Medicaid expansions authorized under the Affordable Care Act – makes the program a crucial vehicle for expanding access.

To inform this project, this white paper identifies Medicaid benefits and financing mechanisms that could be used to improve uptake and comprehensive delivery of PrEP medication and clinical care. A second white paper describes further ways to leverage the Medicaid program to engage patients and providers in accessing PrEP and utilizing the full suite of recommended PrEP clinical services. The papers will inform a ChangeLab/AcademyHealth convening of Medicaid officials from select states, representatives of managed care organizations (MCOs), public health officials, and patient and provider stakeholders in January of 2019 to consider which of the approaches discussed may be appropriate for their policy environments.

This paper begins with background information on PrEP and PrEP recommended services and on Medicaid, including the current status of state Medicaid expansions and an overview of models and penetration rates of managed care in Medicaid programs.

It then presents a framework for considering the "levers" in the Medicaid program that could be used to increase and improve PrEP delivery:

- **State-level financial policies** that can impact PrEP care, including MCO rate-setting and carveouts, as well as other managed care and value-based design approaches;
- **Benefit design** related to PrEP medication and clinical services, including benefits covered by the state's fee-for-service program, additional benefits that MCOs can offer, contract approaches to aligning benefits across fee-for-service (FFS) and managed care, and the potential impact of the U.S. Preventive Services Task Force (USPSTF) draft recommendation for PrEP;
- **Performance improvement**, based on reporting or incentives at the plan and provider levels;
- **Access to PrEP providers** in managed care Medicaid, as shaped by state policies on network adequacy and on MCO network decisions; and
- **Partnerships** with local health departments or community-based organizations (CBOs), and how states and MCOs can identify and support them.

The paper continues with an overview of Medicaid financing issues for PrEP that are specific to certain types of providers and settings: nurse practitioners and physician assistants, registered nurses (RNs), pharmacists, and federally-qualified and rural health centers. It closes with a discussion of two key overarching considerations: the potential uses of Medicaid claims data to support the use of PrEP medication and clinical care, and the importance of information on PrEP's return on investment (ROI) to effect change within the Medicaid program – at the state level or with specific MCOs.

Every state differs in its HIV epidemic, its resources, its Medicaid program, and the relationship between the HIV/public health community and the Medicaid agency. This paper does not present a one-size-fits-all answer to improving PrEP access through Medicaid. Rather, the goal is to outline in one place the potential tools that state-level stakeholders could use to identify and address barriers in their states, taking into account fiscal and political feasibility. Table 1 contains a high-level summary of issues to consider at the state level, based on the topics covered in this paper. After the convening in January 2019, condensed versions of the white papers will be developed as an additional tool to help stakeholders at the state level identify key action items.

Table 1: High-Level Issues to Consider at the State Level

Medicaid Landscape
What categories of Medicaid eligibility in the state are available to people who are using or are candidates for PrEP?

Has the state expanded Medicaid, facilitating access for a broad set of low-income adults?

Does the state have a Medicaid family planning expansion program, which may facilitate access to some PrEP medication or clinical care services such as sexually transmitted infections (STIs) and HIV screening?

What role do comprehensive MCOs play in the state's Medicaid landscape?

State Level Financial Policies
How can current and projected PrEP uptake be meaningfully reflected in the rates that states pay Medicaid MCOs as well as in the risk-adjustment formula applied?

Is the medication for PrEP carved out of the state's managed care contracts, and if so, how does this influence access to medication and clinical services?

Should the state consider carving the full set of PrEP services out of managed care?

Are there innovative payment models in the state Medicaid program, such as Medicaid health homes, accountable care organizations (ACOs), or others, that could be used or modified to support PrEP?

Benefit Design
What is the state's policy on Medicaid coverage of telehealth, and how might it affect access to and use of PrEP clinical care?

Does the state's Medicaid FFS program apply limits, such as prior authorization requirements, to medication for PrEP? Are they aligned with PrEP care requirements such as confirming ongoing negative serostatus, or do they pose inappropriate barriers to access?

Does the state FFS program pay consistently for PrEP clinical services, including multisite STI testing, as recommended by the CDC?

Does the state FFS program cover optional benefits that could be used to support PrEP, such as targeted case management?

Beyond the benefits in the state Medicaid package, do Medicaid MCOs offer additional services that are relevant to PrEP, such as care coordination services? If so, is PrEP a qualifying condition? Can and should it be?

What approaches can the state use to align coverage policies for PrEP medication and clinical services across the FFS program and MCOs?

Performance Improvement
What programs does the state have to monitor and reward MCO performance, and how could PrEP measures be integrated?

Does the state have a system for performance incentives to Medicaid FFS providers that could be leveraged to support comprehensive PrEP services?

Can support and incentives for offering PrEP clinical services be integrated into existing MCO provider payment models, such as performance incentives or bundled payments? How?

Access to PrEP Providers
How can the state assess the availability of PrEP providers in the Medicaid FFS program?

Are Medicaid MCOs in the state including PrEP providers in their networks? How can the state and MCOs work together to assess and track PrEP provider access?

Partnerships with Local Health Departments and Community-Based Organizations
How could the state Medicaid agency work with local health departments and CBOs to promote use of PrEP medication and clinical services?

Could the state require or encourage MCOs to work with local health departments, CBOs or community health workers to promote use of PrEP medication and clinical services? If so, what would this look like?

Specific Considerations Linked to Provider Type and Setting
Are nurse practitioners and physician assistants who provide PrEP able to bill Medicaid for all components of the intervention?

How can the state Medicaid program better support pharmacist engagement in PrEP medication management and clinical service delivery, including through a state Medication Therapy Management (MTM) benefit?

Are public/local health department clinics able to bill Medicaid if they offer PrEP?

Do the state's Medicaid reimbursement rates for Federally-Qualified Health Centers and Rural Health Centers adequately support and incentivize comprehensive provision of PrEP?

Further Considerations
How can Medicaid and public health use existing data to evaluate PrEP access and PrEP uptake, as well as the quality of PrEP care?

What kinds of cost information do Medicaid and MCOs need to inform design of PrEP benefits and delivery?

Table 2: Experts Interviewed for the Project

Divya Ahuja, MD, University of South Carolina Associate Professor of Clinical Internal Medicine

Jennifer Babcock, MPH, Vice President for Medicaid Policy and Director of Strategic Operations, Association for Community Affiliated Plans

Laura Beauchamps, MD, University of Mississippi Medical Center, Assistant Professor Infectious Disease; Medical Director, Open Arms Healthcare Center

Sean Bland, JD, Senior Associate, O'Neill Institute, Georgetown Law*

Sarah Calabrese, PhD, Assistant Professor of Psychology, George Washington University

John Carlo, MD, Member, American Medical Association (AMA) Council on Science and Public Health; CEO, Prism Health North Texas

Stephen Cha, MD, Chief Medical Officer of UnitedHealthcare Community & State

Megan Coleman, FNP, Director of Community Based Research, Whitman-Walker Health, DC

Edwin Corbin-Gutiérrez, MA, Senior Manager, Health Systems Integration, National Alliance of State and Territorial AIDS Directors*

Jeffrey S. Crowley, MPH, Distinguished Scholar and Program Director of Infectious Disease Initiatives, O'Neill Institute, Georgetown Law*

Vanessa Diaz, MD, MSCR, Medical University of South Carolina

Jason Farley, PHD, MPH, ANP-BC, AACRN, FAAN, Co-Director Clinical Core, Hopkins Center for AIDS Research; Immediate-Past President, Association of Nurses in AIDS Care (ANAC)

Douglas Fish, M.D., Medical Director, Division of Program Development & Management, New York State Department of Health*

Andrea Gelzer, MD, MS, FACP, Senior Vice President & Corporate Chief Medical Officer, Amerihealth/Caritas

DeAnn Gruber, PhD, MSW, Director of the Bureau of Infectious Diseases, Louisiana Department of Health*

Elizabeth Hacker, MPH, PrEP Coordinator, Detroit Public Health STD Clinic

Chad Hendry, Director of Sexual and Reproductive Health, Howard Brown Health

Kristin Keglovitz-Baker, PA-C, Chief Operating Officer and Certified Physician Assistant, Howard Brown Health

Amy Killilea, JD, Director, Health Systems Integration, National Alliance of State and Territorial AIDS Directors

Douglas Krakower, MD, Research Scientist, The Fenway Institute; Assistant Professor of Medicine and Population Medicine, Harvard Medical School; Harvard Medical Faculty Physician at Beth Israel Deaconess Medical Center

Leighton Ku, PhD, MPH, Professor and Director of the Center for Health Policy Research, George Washington University School of Public Health

Paul Loberti, MPH, Administrator for Medical Services, Project Director Health System Transformation, Project Director HIV Provision of Care & Special Populations Unit, Health & Human Services, State of Rhode Island*

Erin Loubier, JD, Senior Director for Health and Legal Integration and Payment Innovation, Whitman-Walker Health, DC

Juan Carlos Loubriel, Director of Community Health and Wellness, Whitman-Walker Health, DC

Kathryn Macomber, MPH, Director, Division of HIV/STD Programs, Michigan Department of Health and Human Services*

Kathy McNamara, RN, Associate Vice President, Clinical Affairs, National Association of Community Health Centers (NACHC)

David Neff, MD, Chief Medical Director, Michigan Department of Health and Human Services*

Sable Nelson, Esq, Policy Analyst, NMAC

Marty Player, MD, Medical University of South Carolina

Daniel Raymond, Deputy Director of Planning and Policy, Harm Reduction Coalition

Catherine Reid, MD, Office of Medical Affairs, Michigan Department of Health and Human Services*

Sandra Robinson, MBA, Chief, ADAP Branch, Office of AIDS, California Department of Public Health

Sara Rosenbaum, JD, Harold and Jane Hirsh Professor of Health Law and Policy and Founding Chair of the Department of Health Policy, George Washington University School of Public Health

David Rzeszutko, MD, Medical Director, Priority Health (Michigan)

Matt Salo, Executive Director, National Association of Medicaid Directors

Bellinda Schoof, MHA, CPHQ, Division Director, Health of the Public and Science, American Academy of Family Physicians (AAFP)

Lyn Stevens, MS, NP, ACRN, Medical Director, AIDS Institute, New York State Department of Health; Past President, Association of Nurses in AIDS Care (ANAC)*

Donna Sweet, MD, MACP, AAHIVS, Director, KU Wichita Internal Medicine Midtown and Ryan White Programs; Director and Principal Investigator, Kansas AIDS Education and Training Center

Elyse Tung, PharmD, BCACP, Kelley-Ross Pharmacy Group, Seattle

Gretchen Weiss, MPH, Director of HIV, STI, and Viral Hepatitis, National Association of County and City Health Officials (NACCHO)

Melody Wilkinson, DNP, APRN, FNP-BC, Member, American Association of Nurse Practitioners (AANP); Program Director of the Family Nurse Practitioner Program and Assistant Professor, Georgetown University

Doug Wirth, MSW, President and CEO, Amida Care (NY)

Mike Wofford, PharmD, Chief Medi-Cal Pharmacy Policy, CA Department of Healthcare Services

** Interviewed by AcademyHealth staff in preliminary interviews*

Methodology

AcademyHealth conducted initial discussions with the project Steering Committee (see Appendix 1) to identify the appropriate scope for this white paper. AcademyHealth staff then conducted preliminary interviews with a set of key informants to begin to develop key themes and topics for the convening and white papers (see Table 2; preliminary interviews conducted by AcademyHealth are marked with an asterisk).

The author then conducted semi-structured interviews with additional experts in Medicaid, PrEP, and patient and provider engagement (see Table 2). Interviews of multiple staff at the same organization or agency were combined.

All interviews were conducted for the overall project, with insights from the experts incorporated into both white papers.

The author also conducted a search of peer-reviewed and "grey" literature on Medicaid and PrEP, as well as on Medicaid financing mechanisms.

AcademyHealth conducted an informal survey of the participants in its Medicaid Medical Directory Network (MMDN) regarding their Medicaid coverage of PrEP medication and clinical care, as well as provider and patient engagement. De-identified responses from 16 states are included in this and the second white paper.

Background

PrEP and the CDC's Guidelines

Pre-exposure prophylaxis for HIV, or PrEP, refers to the daily use of a medication by people who are HIV-negative to reduce the risk of seroconversion. Trials have demonstrated effectiveness of over 90 percent for consistent use among those at risk of sexual transmission, and over 70 percent for people who inject drugs.[7] This section outlines the components of the full suite of PrEP services, as well as the populations for whom it is indicated, as context for the discussion of the scope and limitations of Medicaid coverage of PrEP.

There is only one drug currently approved by the FDA for PrEP in the US: a fixed-dose combination of tenofovir disoproxil fumarate (TDF) 300 mg and emtricitabine (FTC) 200 mg, sold by Gilead as Truvada. All states must cover Truvada for PrEP in their Medicaid programs, but there is variation across and within states in whether barriers to access exist. The FDA granted ANDA approval to Teva[8] and Amneal[9] for generic versions of Truvada in June 2017 and August 2018, respectively. However, neither has yet become available on the U.S. market.

The CDC recommends PrEP be considered as one prevention option for the following people at substantial risk of HIV infection[10]:

Men Who Have Sex with Men (MSM) (including those who inject drugs)

- HIV-positive sexual partner
- Recent bacterial STI (gonorrhea, chlamydia, syphilis)
- High number of sex partners
- History of inconsistent or no condom use
- Commercial sex work

Persons Who Inject Drugs

- HIV-positive injecting partner
- Sharing injection equipment

Heterosexual Women and Men (including those who inject drugs)

- HIV-positive sexual partner
- Recent bacterial STI (gonorrhea, syphilis)
- High number of sex partners
- History of inconsistent or no condom use
- Commercial sex work
- In high HIV prevalence area or network

In order to determine clinical eligibility, the guidelines recommend a documented negative HIV test result; an assessment to rule out signs or symptoms of acute HIV infection; a renal function test (estimated creatinine clearance); and assessment of current medications to rule out contraindications. While not a clinical eligibility criterion, documentation of Hepatitis B infection and vaccination status is recommended prior to initiating PrEP. The CDC recommends that once on PrEP, people receive a follow-up visit at least quarterly for an HIV test, medication adherence counseling, behavioral risk reduction support, side effect assessment, and STI symptom assessment. Renal function testing is recommended at 3 months and every 6 months thereafter. Overall, bacterial STI testing is recommended every 3-6 months for both sexually active men and women. The CDC recommends nucleic acid amplification (NAAT) STI testing at sites of potential sexual exposure including pharyngeal and rectal testing for MSM, as well as rectal testing for women who report engaging in anal sex. Providers should offer pregnancy tests and discussion of pregnancy intent with women every six months, and people who inject drugs should have access to clean needles and drug treatment services.

The discussions of state Medicaid benefits and of Medicaid MCO coverage policies below review key opportunities for, and barriers to, coverage of this set of services.

The Range of Medicaid Policy and Program Environments

Most elements of the Medicaid program – including eligibility, benefits, and financing mechanisms – vary significantly from state to state. This section describes the range of Medicaid policy and program environments, with an emphasis on those features that are relevant to the coverage of PrEP medication and clinical services.

Low-income uninsured patients who do not qualify for Medicaid may be able to access Truvada through the manufacturer's assistance program, which currently offers eligibility up to 500 percent of the federal poverty level for U.S. residents.[11] However, people without insurance may not have a source of assistance to cover PrEP clinical care services and laboratory tests. State and local PrEP assistance programs, such as those offered by Washington State,[12] New York State,[13] and Washington DC,[14] could help fill these gaps but are not widely offered.

Medicaid Eligibility

Eligibility for Medicaid for various populations eligible for PrEP depends on the state and is based on age, household income, and other demographic factors.

Eligibility Categories

Adolescents and pregnant women may be candidates for PrEP; both populations are eligible for Medicaid in all states. In all but two states, children and adolescents through age 18 are eligible for coverage, either through Medicaid or CHIP, up to income levels of at least 200 percent of the federal poverty level (FPL).[15] Approximately two-thirds of states (33 plus DC) cover pregnant women with income levels up to 200 percent FPL or higher; the remainder set eligibility for pregnant women between 138-200 percent of FPL.[16] People with disabilities who are Supplemental Security Income (SSI) beneficiaries are eligible up to thresholds of at least 73 percent in most states.[17]

If a candidate for PrEP is the parent of dependent children, Medicaid may be available, but the income cutoff is quite low in the 19 states that have not expanded Medicaid: in 11 of the 19 non-expansion states, eligibility for parents of dependent children is set lower than 50 percent of the FPL.

Overall, "lawfully present" immigrants may be eligible for Medicaid depending on income level, but in most states non-pregnant adults face a five-year waiting period after obtaining qualified status; in roughly half the states, children and pregnant women face the same waiting period.[18] For the most part, undocumented immigrants are not eligible for Medicaid, other than through a narrow set of exceptions that would not be relevant for most PrEP users.[19] U.S. residents are currently eligible for the manufacturer's assistance program for Truvada, regardless of citizenship status.

Medicaid Expansion

The importance of Medicaid coverage for HIV prevention increased significantly with the Affordable Care Act, which permits states to extend Medicaid eligibility to all adults up to 138 percent of the federal poverty level. As of July 27, 2018, 33 states plus DC had enacted expansions[20]; on election day in November 2018, three more states (ID, NE, and UT) enacted expansions by ballot initiatives.

State Medicaid expansions have significantly increased rates of insurance coverage overall. By the end of 2016, the 31 states that had expanded Medicaid, along with DC, reported a total of 14.9 million enrollees in the adult expansion group.[21]

Studies have found dramatic increases in Medicaid enrollment in expansion states among populations relevant to PrEP. For example, lesbian, gay and bisexual people experienced an increase in Medicaid enrollment from 7 percent to 15 percent from 2013 to 2016, reflecting an increase of over 500,000 people.[22] Rates of uninsurance among young adults dropped significantly in expansion states, from 34.5 percent to 24.3 percent between 2013 and 2014.[23] Overall, the Medicaid expansion has been found to reduce income- and age-based disparities in insurance coverage; improve some insurance disparities by race and ethnicity; and positively impact access to care across most studies.[24]

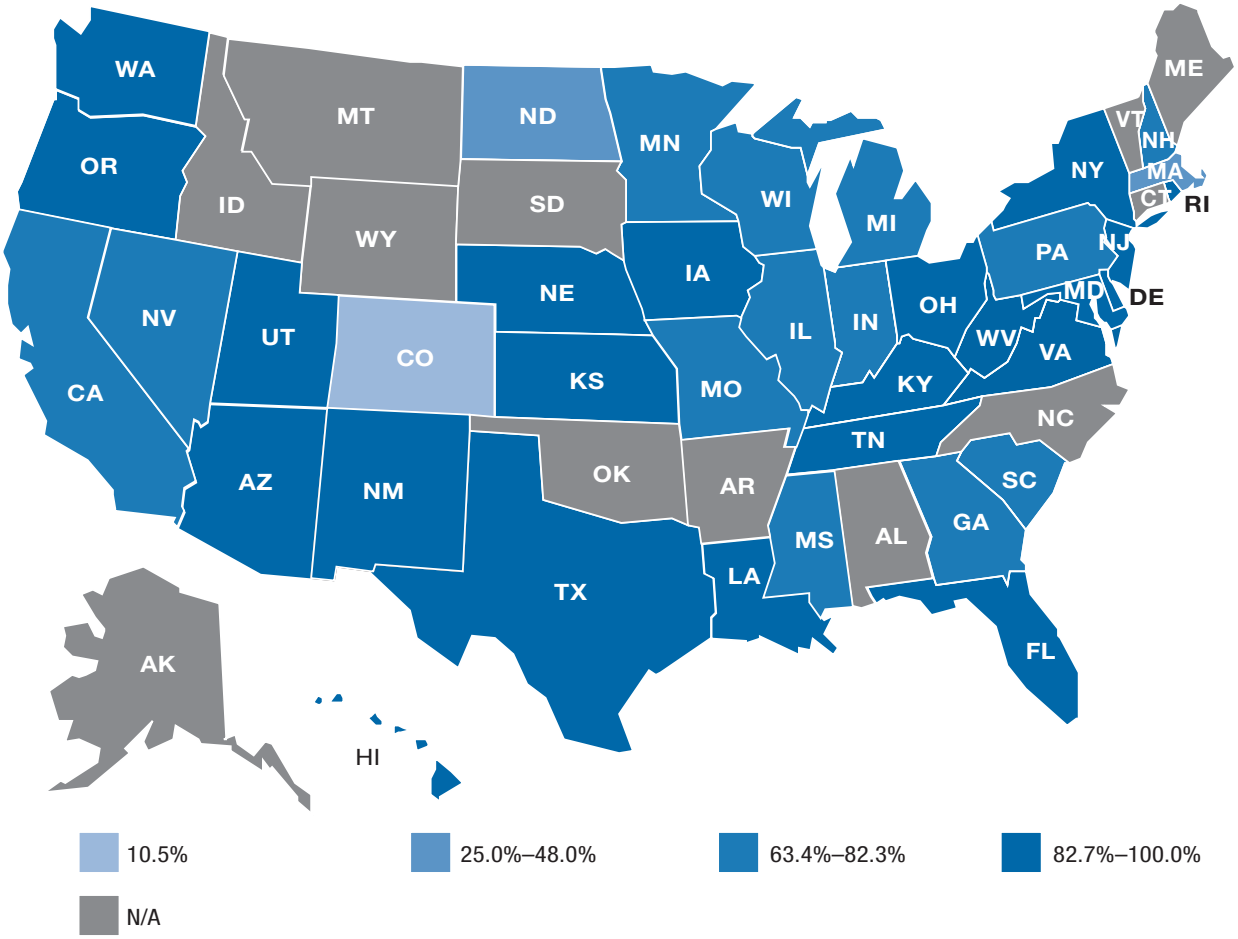
Medicaid Family Planning Eligibility Expansions

States have the option to create Medicaid family planning expansion programs that offer coverage of family planning services to people who are not otherwise eligible for Medicaid. These programs cover a narrow range of services, and it does not appear that any state currently covers Truvada itself through a family planning expansion.[25] However, the programs can be an important way to reach people with certain PrEP clinical services, including HIV and STI testing and visits, while connecting people to the manufacturer assistance program for the medication.

For example, the Open Arms Healthcare Center in Jackson, Miss., currently has approximately 200 patients on PrEP. For patients who are uninsured, a staff person submits an application to the Medicaid family planning program. For those eligible, the program covers up to four visits a year as well as labs, including STI testing and treatment, therefore reimbursing for several key components of the PrEP intervention.[26]

As of June 2017, 26 states had expanded Medicaid eligibility for family planning services under either a waiver or a permanent state Medicaid plan provision.[27] In 22 of these states, eligibility is based on income, usually set at a threshold around 200 percent FPL.[28] Nineteen states cover both men and women, with the remainder covering only women.[29]

Figure 1: From KFF, Medicaid Comprehensive MCO Penetration Rate: Total Population, as of July 1, 2017



This program may be particularly important for PrEP clinical services in states that have not expanded their overall Medicaid programs. Alabama, Florida, Georgia, Mississippi, North Carolina, Oklahoma, South Carolina, and Wyoming are non-Medicaid expansion states that did have *family planning* expansions as of 2017; all but Florida, Georgia, and Wyoming covered men.[30] In addition, even in states with Medicaid expansions, Medicaid family planning programs often cover people up to higher income thresholds, thereby reaching people who are not eligible for full Medicaid.

The scope of services covered by each state's family planning expansion program varies. As of 2009, the most recent year for which survey data was identified, 22 states' Medicaid family planning expansion programs included coverage of STI testing and labwork (though this may not extend to multisite testing or tests at the frequency recommended for PrEP); 11 also covered STI treatment.[31] Eighteen states reported covering HIV testing.[32] Some state family planning expansions also cover condoms, generally with a prescription.[33]

Fee-for-Service Medicaid

Fee for service (FFS) describes the traditional model of Medicaid, in which state Medicaid agencies pay physicians or other health care providers for each service delivered to a Medicaid beneficiary. In most states, at least some enrollees are enrolled in the FFS program (see next section for data on penetration of managed care). As discussed throughout this paper, state Medicaid agencies can have a direct role in implementing financing mechanisms to influence provider behavior through FFS payments and requirements.

Medicaid Managed Care: Landscape

In recent decades, states have significantly expanded their use of managed care approaches within the Medicaid program. Generally, Medicaid managed care refers to a range of arrangements under which states contract with entities that accept a fixed payment to provide a certain set of services to members. To inform potential approaches for bolstering PrEP intervention services, this section provides an overview of comprehensive managed care in Medicaid, and discusses managed care penetration rates – that is, the percent of Medicaid beneficiaries who are comprehensive managed care enrollees – by state.

Comprehensive MCOs

The most common model of managed care in Medicaid is comprehensive "risk-based" managed care. In this model, states contract with plans to cover all or most services to Medicaid enrollees.[34]

MCOs receive a fixed monthly payment, called a capitation payment, for each enrollee, regardless of which if any services are received that month. Some states "carve out" certain benefits from managed care, continuing to pay for those services on a FFS basis. Regardless of which services are carved out in a given state, MCO enrollees as well as enrollees in other managed care arrangements are entitled by federal regulation to all services available under the state plan, including PrEP medication and all covered PrEP clinical services.[35]

Comprehensive Medicaid Managed Care Penetration

Because Medicaid managed care poses distinct challenges and opportunities for promoting uptake of PrEP medication and clinical care, it is important for stakeholders to understand how much of their state's Medicaid population is enrolled in managed care. In 2016, approximately two thirds of all Medicaid beneficiaries were enrolled in comprehensive MCOs.[36] However, the proportion varies widely by state[37]:

Managed care enrollment also varies by eligibility category. In a national survey of state Medicaid agencies regarding enrollment in comprehensive MCOs,[38] most states reported that managed care penetration among nondisabled, nonelderly, non-pregnant adults was at least as high as that of the total population as reflected in the map above.

There is significant variation in the *number* of MCOs operating in each state with managed care, from one in North Dakota to 23 in New York.[39] To the extent different financing ideas discussed in this report would need to be broached with MCOs directly, it would be important to understand how many plans that would entail, as well as, potentially, the number of Medicaid enrollees each covers.[40]

Promoting PrEP Medication and Clinical Care through Medicaid and Medicaid Managed Care

This section explores mechanisms to support the provision of PrEP medication and clinical services within FFS Medicaid and Medicaid managed care. Given the variation in state Medicaid benefits, eligibility, and payment models, no one approach will be appropriate in every state. This section will track the financing and contractual relationships among parts of the Medicaid system to identify potential opportunities for stakeholders to consider in their respective environments.

The chart in Appendix 2 provides a visual framework for considering the key parties and "levers" to promote PrEP in Medicaid.

Role of CMS

As the federal agency administering the Medicaid program, the Centers for Medicare and Medicaid Services (CMS) could potentially play several roles in Medicaid financing of PrEP medication clinical services. CMS's Center for Medicaid and CHIP Services (CMCS) must administer the program within the bounds of federal statute but works closely with states in a variety of ways.

CMCS can send Informational Bulletins or Dear State Medicaid Director letters to all state Medicaid agencies, to inform them of news, obligations, or opportunities in the Medicaid program. In December 2016, CMCS sent a joint Informational Bulletin, along with the Department of Health and Human Services, Health Resources and Services Administration (HRSA), and the CDC, regarding "Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries."[27] The section on PrEP included specific examples of financing approaches states can take to improve access to STI screening and other clinical services:

> States have the discretion to establish certain limitations, prior authorization processes or preferred drug lists, on the coverage of PrEP to ensure appropriate utilization when medically necessary; however, we encourage states to take steps to ensure that PrEP is available consistent with USPHS recommendations. For example, neither Colorado nor Washington State subject emtricitabine/tenofovir to prior authorization processes when it is prescribed for HIV treatment or HIV PrEP. Because regular HIV and STD tests are recommended for persons who initiate PrEP, Washington's Medicaid program also facilitates access to these testing services by covering their receipt on a quarterly basis and in a range of settings that may be more convenient or comfortable for beneficiaries (e.g., family planning clinics, local health departments, or primary care settings). States should ensure that beneficiaries being initiated on PrEP are educated about and provided with sufficient supportive care to ensure adherence to regimens. Additional strategies states may consider to ensure that utilization management techniques are not designed or implemented in ways that amount to denial of access to PrEP among persons for whom it is indicated include 1) provider education, 2) development of clear policies and procedures for assessing and making determinations about indications for PrEP, and 3) careful review and monitoring of Medicaid FFS and managed care benefits and coverage.[28]

CMS could build on this informational bulletin to help guide state Medicaid agencies, and could consider whether further clarification (e.g. regarding coverage of multisite STI testing) is warranted. In addition, CMS could consider developing technical assistance for states in scaling up PrEP under Medicaid, similar to the work the agency has done to support best practices and models for addressing the opioid epidemic.[41]

State-Level Financial Policies

This section describes several key state-level financing decisions that may impact coverage of PrEP medication and clinical care within the Medicaid program: rates paid to MCOs, and how they may (or may not) reflect PrEP costs; decisions about carving components of PrEP care out of managed care; considerations for PrEP in non-comprehensive managed care models; and the potential integration of PrEP into value-based payment models in Medicaid.

Capitation Rates and Risk Adjustment: An Overview

States pay Medicaid MCOs a monthly rate for each enrollee in the plan. Under federal statute and regulations, the rate must be "projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract."[42]

Within these and further regulatory parameters, states and plans generally develop a base premium by taking into account multiple factors including baseline data, expected trends, state fiscal conditions, services that are carved out of managed care, payments in addition to the base capitation rate, and incentives.[43]

As a relatively new intervention, the cost of PrEP is likely not fully reflected in current base rates. Therefore, the impact of scaled-up PrEP use on rates could be projected by actuaries and factored into future rates. Ultimately, as PrEP uptake increases and is reflected in utilization data, the cost of the drugs and clinical services would be reflected in the capitated rate.

To reflect variation in actual plan enrollment across MCOs, states apply a risk adjustment based on factors including eligibility category, age, gender, region, and health status. With regard to health status, states vary in the risk adjustment model used, with most relying to some extent on diagnostic codes, several relying on analysis of pharmacy data, and others using a hybrid approach.[44]

Interviewees were not aware of currently available techniques to risk adjust enrollees for PrEP use. Even if PrEP risk adjustment models became available, because PrEP uptake is unlikely to be evenly distributed across plans, states will need to work with specific MCOs to develop payment approaches that meaningfully follow actual PrEP uptake. For example, one interviewee noted that states could budget for increased PrEP uptake and distribute money across plans based on projections, but conduct a "true-up" process at year's end to shift funding to where uptake actually occurred.[45]

Another interviewee pointed out that because rates are generally negotiated annually and far in advance of a plan year, there could be a lag between a state's efforts to promote PrEP uptake through MCOs, and an updated base rate and risk adjustment model that reflects that increase in services.[46] Without reflecting increased PrEP utilization in MCOs' rates in some fashion, MCOs could be reluctant to support outreach and education measures, particularly in states where pharmacy is included in the MCO contract.

Setting MCO Rates Based on Projected PrEP Services Uptake: Case Study of New York's HIV Special Needs Plans

New York State has a specialized type of comprehensive Medicaid MCO called HIV Special Needs Plans, or SNPs, specifically for people living with HIV. The plans cover the same Medicaid benefits as other MCOs in the state, along with enhanced services such as HIV care coordination case management, treatment adherence services, and risk reduction education. All primary care providers in the plan must meet state standards for HIV Specialist designation. The state developed specific capitated rates for HIV special needs plans (SNPs) based on prior utilization and cost data for people living with HIV, resulting in a per member, per month rate of approximately $5000 (compared to approximately $800 for general Medicaid managed care plans).[146] There are now three Medicaid HIV SNPs operating in the state.

As of November 2017, all transgender people may enroll in New York's HIV SNPs regardless of serostatus, a change the state made to support access to coordinated, expert services for people at high risk of HIV.[147] Amida Care, the largest HIV SNP, has supported approximately 25 percent of its HIV-negative transgender enrollees in accessing PrEP.[148] Amida is working with the state to expand SNP eligibility to all MSM, regardless of serostatus.

Rate setting for HIV-negative people enrolling in HIV SNPs was based on added costs of PrEP drugs and clinical services, incorporating a projected trended uptake model that estimated the portion of HIV-negative enrollees who would use PrEP.[149]

While HIV SNPs are a unique model, other states could look to New York for lessons in adequately setting rates for PrEP use. Specifically, the methods used to project PrEP costs, as well as trended uptake, may be useful in other settings when applied to PrEP users across non-specialized plans.

Medicaid Carveouts

One important contextual consideration for this section is whether in any state it might be advantageous to carve PrEP medication and clinical services out of MCO contracts entirely, keeping payment in the FFS realm.[47] Of the 39 states with comprehensive MCOs in 2017, the majority included pharmacy in MCO contracts; only four – Missouri, Tennessee, West Virginia, and Wisconsin – carve pharmacy entirely out of MCO contracts. California, Maryland, and Michigan generally include pharmacy in MCO contracts, but reimburse HIV drugs on a FFS basis.[48] Therefore, in those seven states, MCOs would not have financial responsibility for medica-

tion, making them less concerned about the financial impact of utilization. However, MCOs retain responsibility for PrEP clinical services.[49]

This project did not identify any states that have specifically carved PrEP clinical services out of managed care. Arguably, since doing so would remove PrEP entirely from MCOs' cost concerns, such a policy could facilitate beneficiary access, especially if Medicaid claims data or other sources indicate limited access to PrEP through MCOs. However, depending on the details, a carveout might hinder an MCO's ability to coordinate an enrollee's HIV prevention care with their other medical benefits. One potential middle path could involve initially carving out PrEP services, then reversing this policy once the costs and uptake of PrEP within a state are more clearly established and can be incorporated directly into rates.

Addressing PrEP through Non-Comprehensive Managed Care Models

As discussed above, comprehensive managed care offered through MCOs is the dominant form of managed care in Medicaid, but it is not the only model. "Medicaid managed care" can also refer to other financing mechanisms that address a more limited set of benefits or payment arrangements. States with a relevant portion of the population enrolled in limited benefit plans or in primary care case management models can also try to promote PrEP through those frameworks:

- *Limited Benefit Plans:* Limited benefit plans are arrangements in which states contract with entities to provide a subset of Medicaid services for some or all enrollees. These plans include prepaid inpatient health plans (PIHPs), which frequently focus on mental health or substance use benefits and include responsibility for inpatient behavioral health care. For example, under Michigan's Pre-Paid Inpatient Health Plan, all Medicaid enrollees receive certain behavioral health services, including substance use disorder treatment and counseling for several mental illness, from 10 organizations that receive capitated rates from the state, working with County Health Departments.[50] In states with limited benefit plans, it may be worth identifying whether any of the services related to PrEP would fall under those entities' purview, to identify the need for coordination as well as plan and provider education.[51]
- *Primary Care Case Management (PCCM):* As of 2017, 15 states had PCCM programs, in which primary care providers are paid monthly case management fees to coordinate care for assigned enrollees; the percentage of Medicaid population enrolled in PCCM in these states varied from 2 to 90 percent.[52] While the use of PCCMs has been declining and enrollment is generally lower than for comprehensive MCOs, stakeholders in states with significant PCCM enrollment may wish to explore ways to integrate PrEP into provider expectations in the program.

Additional State-Level Value-Based Payment Mechanisms

States can consider building on recent alternative ways of paying for care in Medicaid to support improved provision of PrEP care.

Many states have Patient-Centered Medical Home, or PCMH, initiatives within Medicaid. The PCMH is a model endorsed in 2007 by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA).[53] In a PCMH, a primary care physician and care team are responsible for providing or coordinating all of a patient's care across the health care system and community. In 2017, thirty states reported having at least some Medicaid beneficiaries in a Medicaid PCMH model.[54] Stakeholders can explore whether their state's existing PCMH model would support PrEP use and adherence, or if modifications could be made to increase support of PrEP.

The Affordable Care Act created additional federal funding to support Medicaid Health Homes, a model that builds on the PCMH concept for beneficiaries with chronic conditions. At the core of the financing model are six "health home" services: comprehensive care management, care coordination and health promotion, patient and family support, and referral to community and social support services.[55] All of these services could potentially support the use of PrEP for enrollees at high risk of HIV. For example, care coordination and health promotion could include coordination of enhanced HIV and STI screening and counseling; patient support could include PrEP navigation or adherence counseling; and referral to community and social support services could link PrEP users to CBOs or other entities engaged in PrEP support.

Having, or being at risk of, HIV is a potential qualifying condition for a Medicaid health home under federal law, but states have flexibility in determining whether and how to target their programs. A matrix of current state Medicaid health home models, including qualifying conditions and provider eligibility, is available.[56] A state Medicaid agency could identify whether any existing health homes in the state could be used to support PrEP, and consider initiating discussions with other PrEP stakeholders regarding modifications or developing a new model.

Another payment model growing in popularity in Medicaid is the Accountable Care Organization, or ACO. As of February 2018, twelve states have active Medicaid ACO models, and another ten or more states are pursuing them.[57] In an ACO model, providers share financial risk with regard to their patients, either through a shared-savings formula (usually evolving toward also including shared risk), or through reimbursement on a per-member, per-month basis.[58]

New York's Amida Care MCO currently has an ACO for people living with HIV but is expanding eligibility to HIV-negative people, creating an opportunity for focused efforts to support PrEP for that population.[59] While this structure may be unique, lessons learned from its development could help inform efforts to address PrEP through less targeted ACOs in other states.

Accountable Health Communities (AHCs) are shared-risk models in which the responsible entity goes further "upstream" than ACOs, and is responsible for addressing the social determinants of health in addition to clinical care and support services. Thirty-one communities are currently participating in CMS's ACH Model for Medicare and Medicaid[60]; other ACH approaches, including multi-funder models, are being supported by a range of government and foundation sources.[61] In theory, this model could provide sustainable support for programs that address structural barriers to PrEP and health in general.

Medicaid agencies can work with public health stakeholders to discuss what Medicaid ACO or ACH approaches are already in place in the state, and whether they could be adjusted or expanded to address PrEP.

Benefit Design

While some Medicaid benefit categories are mandatory, states have some discretion to design their FFS coverage packages in ways that may impact whether and how providers offer PrEP clinical services. On the managed care side, Medicaid MCO enrollees are entitled by regulation to all services the state covers.[62] However, different restrictions may apply to medication access, and MCOs can cover benefits beyond a state's basic package. This section provides an overview of how states can align benefits across a Medicaid program through MCO contract provisions. It then reviews key benefits that affect PrEP coverage, including clinical visits, medication, clinical services, labs, condoms, and targeted case management. It continues with an overview of billing and coding for PrEP medication and services, and closes with a discussion of how the USPSTF's new recommendation for PrEP could affect Medicaid benefits.

Aligning PrEP Coverage Through MCO Contracts

In some states, it may be feasible to specifically write PrEP standards into MCO contracts – addressing not only medication but also the other benefits discussed in this section. In general, there is considerable variability in the scope and granularity of the coverage requirements that Medicaid programs apply to MCOs by contract. For example, with regard to HIV broadly, a review of selected states' Medicaid MCO model contracts found that three (Florida, New York, and Texas) had detailed contract language regarding HIV clinical services; four (DC, Massachusetts, New Mexico, and Pennsylvania) had minimal specifications; and two (Georgia and Illinois) did not address HIV clinical services.[63] Understanding how prescriptive states have been in their contracts with MCOs is important context for conversations about potential contract requirements related to PrEP.

Even if a state's contracts with MCOs do not explicitly mention PrEP, a state Medicaid agency can reach out to MCOs that are not reimbursing services that the state FFS program would cover to explain why they must bring their policies into alignment. For example, in California, even though HIV is carved out of managed care contracts, claims analysis identified that in some MCOs, fewer enrollees than expected were receiving PrEP. The Medi-Cal program reached out to MCOs, both formally and informally, to discuss making their coverage of PrEP comparable to the FFS benefit. These conversations, typically with a plan's medical director, tended to result in increased PrEP uptake among the plans' enrollees as reflected in claims analyses.[64] Similarly, public health officials in Louisiana were able to educate MCOs that multisite STI test claims were neither repeat tests nor errors, but a recommended component of PrEP intervention services.[65]

State Medicaid agencies, public health agencies and providers can work together to determine approaches to aligning coverage policies across the state program to support comprehensive coverage of PrEP services. Whether to rely on general requirements that MCOs cover all state benefits, or to seek specific benefit requirements in the contract, is a state-specific question that should be discussed with each Medicaid agency.

Access to State Medicaid Contracts

Generally, states have "model" Medicaid contracts. While some may negotiate specific terms differently with different MCOs, these model contracts generally reflect overall state expectations and requirements for participating MCOs. Many states' model contracts are available online; others can be requested directly from the state Medicaid agency. Requestors should ensure that any relevant accompanying documents – such as requests for proposals (RFPs) with provisions to be incorporated in the contracts – are included.

Office Visits and Telehealth

All Medicaid programs cover office visits at various levels of complexity; the National Alliance of State & Territorial AIDS Directors (NASTAD) report described in the billing section of this report offers specific recommendations for visit types to consider using to bill for PrEP initiation, shared medical visits, and counseling.

A growing consideration for PrEP programs is access to telehealth services – clinical services offered where the patient and the practitioner are communicating in real time over a telecommunica-

tions system – to reduce patient burden for the regular screenings and visits recommended for PrEP users.[66] States have considerable flexibility to determine whether to cover telehealth services in their Medicaid programs. As of spring 2018, 49 states and DC provide for Medicaid reimbursement of some form of live video telehealth services.[67] Roughly half of states specify a specific set of facilities that can serve as "originating sites" where the patient may be; only ten states permit a patient's home to be the originating site.[68]

Telehealth coverage in Medicaid can vary by service type. Among MCOs, for example, a 2017 survey found that 37 percent of Medicaid MCOs use telemedicine for mental health or SUD counseling, along with 20 percent for chronic disease management; 32 percent did not use telemedicine.[69] In addition, some multistate Medicaid MCOs provide their enrollees with free access to national telehealth service providers, like Teladoc.[70] Telehealth providers with specific PrEP programs include Nurx and Plushcare.[71]

Stakeholders can try to work within these parameters to promote reimbursement for PrEP and PrEP clinical services, or attempt to change a state's requirements to meet the needs of PrEP patients and providers. Where MCOs are making general services like Teladoc available, the plans could work with public health and clinical partners to explore how any counseling or STI screening facilitated through the service can be coordinated with a patient's other providers as appropriate.

Medication

While states generally have considerable flexibility in Medicaid with regard to coverage of preventive services, they *must* cover Truvada under the Medicaid National Drug Rebate Agreement. Under the terms of the Agreement, manufacturers make drugs available to Medicaid plans with significant rebates, and in turn, states' formularies must include all of those manufacturers' drugs.

However, states can establish their own utilization management techniques to limit use of a drug by FFS enrollees. For example, states can maintain preferred drug lists (setting higher cost sharing for non-preferred drugs); require prior authorization based on certain clinically justified parameters; set limits on use (e.g. quantity limits on the total number of prescriptions per month); or decline to cover off-label uses.

States can choose to eliminate prior authorization on Truvada entirely. Of 16 states responding to an informal AcademyHealth survey of Medicaid Medical Directors, 12 reported having no prior authorization or other utilization management requirements on Truvada for PrEP within their FFS programs.[72]

A brief prior authorization requirement, for example requiring a physician to confirm that the patient is HIV-negative, may be both medically reasonable and not unduly burdensome.[73] However, to the extent a state applies restrictions that increase provider burden (e.g. lengthy prior authorization requirements), provider participation in PrEP – and therefore in PrEP clinical services, could be limited.

State Medicaid agencies should assess any FFS prior authorization requirements for Truvada as PrEP to assess whether they serve as useful clinical tools or unnecessary barriers to care. They could work with providers in the state as well as public health officials to identify an appropriate PA policy for the state FFS program.

In most states, MCOs can place different controls on utilization of covered medications. For example, one interviewee reported that some MCOs in New York State have reportedly applied prior authorization requirements for PrEP that operate as a "speed bump" to access.[74]

Some states apply standardized or "common" Medicaid formularies, requiring MCOs to use the same set of utilization management approaches, either to all pharmacy or to a particular drug or drug class.[75] State Medicaid programs could consider whether to apply this approach for PrEP medication to create consistent access.

STI Testing and Treatment

Medicaid FFS programs typically cover some STI testing as well as the other clinical components of the PrEP intervention, such as HIV screening, pregnancy testing for women, and other lab tests.

However, programs may not formally cover testing on a quarterly basis and may not always cover the multisite STI testing required for some PrEP users. For example, the CDC recommends that for MSM receiving PrEP, quarterly gonorrhea and chlamydia nucleic acid amplification test (NAAT) be conducted on pharyngeal, rectal, and urine specimens ("3-site testing"). The CDC recommends NAAT testing of vaginal specimens for women who engage in vaginal but not anal sex, and of both vaginal and rectal specimens for gonorrhea and chlamydia among women who report engaging in anal sex.[76] Medicaid payment systems may reject multiple claims for tests for the same disease for the same person on the same day, either because of a specific payment policy, or because systems are simply not designed to accept multiple lab claims for one disease in a given day.

In AcademyHealth's informal survey of the Medicaid Medical Director Network regarding PrEP coverage, respondents were asked if their state FFS program would "pose any barriers to coverage of quarterly, multi-site STD testing." Of 15 states with FFS programs

responding, seven stated that the program would not pose barriers; one stated that the program wouldn't pay for a second test on the same day; and seven were indeterminate, with answers including "depends," "I do not believe so," and "probably." These responses suggest that state Medicaid agencies could start by clarifying whether their own policies and systems support multisite, quarterly testing without barriers.

MCO practice also varies with regard to STI claims. For example, Dr. Divya Ahuja of University of South Carolina indicated that among his PrEP patients, he perceives a smoother process for approval of multisite screening for FFS enrollees; MCOs seem to more frequently require one or more calls from a physician or other staffer before approval is granted (though his office had not formally evaluated this pattern).[77] An MCO interviewee suggested that rejections of multisite STI testing claims are more likely to reflect logistical issues like automatic payment systems, rather than specific policies against covering multisite testing.

Challenges associated with claims for multi-site STI testing are not specific to Medicaid. One provider in a non-Medicaid expansion state reported frequent rejections or pushback for multisite STI claims for *privately*-insured patients, as well as significant variation in how private plans manage PrEP-related codes, resulting in a lowered likelihood of additional revenue for billing all components of PrEP.[78] This suggests that multi-payer approaches or alternative payment models could create a more consistent billing and reimbursement environment for PrEP providers.

Lab Validation

Not all labs have undergone validation to support extra-genital (pharyngeal or rectal) site testing, posing a barrier to the multisite testing recommended for most PrEP users.[150] This problem is not unique to Medicaid but must be addressed to allow Medicaid reimbursement. Public health departments and Medicaid agencies could work to ensure that all labs receiving Medicaid reimbursement in the state can conduct validated testing on all types of specimens, or alternatively that enough Medicaid-participating labs are available to meet demand.

State Medicaid agencies and their MCOs can assess their lab reimbursement protocols for STIs to identify and address any barriers to reimbursement of PrEP-associated labs. If needed, the state Medicaid agency and MCOs could work with public health experts to align coverage policies with CDC guidelines. For example, public health officials in Louisiana became aware that the state Medicaid program was rejecting lab claims for multi-site STI tests, only allowing one claim to go through. They were able to work with the office to achieve reimbursement for two sites; the public health staff will be revisiting the issue to confirm if three-site reimbursement is now occurring.[79]

Challenges regarding Medicaid coverage of other tests recommended as part of PrEP, including HIV and hepatitis B tests, as well as renal function tests, have not been identified in the literature or interviews, but could similarly be discussed with state Medicaid agencies and MCOs if problems arise.

Condoms

The CDC's PrEP guidelines note that "[t]he importance of using condoms during sex, especially for patients who decide to stop taking their medications, should be reinforced."[80] In many states, Medicaid can reduce financial barriers to condom use. As of July 2015, 27 states of 41 responding to a survey reported covering condoms in their traditional (non-expansion population) Medicaid programs; 18 reported covering condoms for their expansion populations and 18 under their Medicaid family planning expansions waivers or amendments.[81] The majority of states covering condoms require prescriptions for reimbursement.

Because condoms require a prescription to be covered, Medicaid and public health stakeholders should ensure that providers are aware of the appropriate procedures to prescribe condoms for PrEP users to trigger Medicaid reimbursement.

Case Management, Care Coordination, and Peer Support

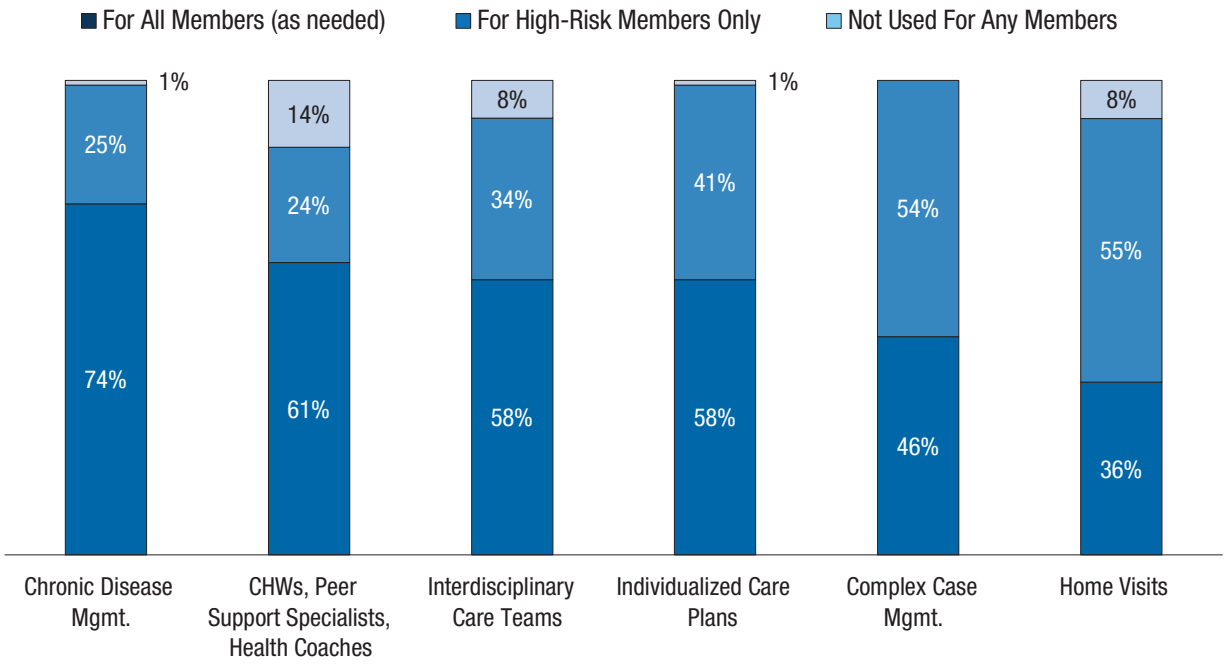
Services to help coordinate and support care for PrEP users could be implemented as a state benefit or as an "additional" service covered by an MCO.

Targeted Case Management

Targeted Case Management (TCM), an optional Medicaid benefit, allows states to cover enhanced case management services to help certain categories of beneficiaries (or beneficiaries in certain parts of a state) access medical and other services. Because TCM can be developed for specific populations – e.g. adolescents, men who have sex with men – it could be developed in a way that addresses specific barriers to PrEP use and adherence to PrEP medication and clinical services. A number of states' Medicaid programs include targeted case management for people living with HIV. Rhode Island has expanded this concept to make TCM available for certain beneficiaries at high risk of HIV,[82] creating a reimbursement mechanism for services around linking people to PrEP and encouraging their adherence to PrEP clinical services.[83]

Medicaid agencies, public health agencies and PrEP providers could explore whether their states have existing TCM benefits that could be modified to support beneficiaries who are candidates for PrEP and other services, or whether such a benefit can or should be developed.

Figure 2: Share of Medicaid MCOs Using Strategies to Promote Coordinated Care



NOTES: "Don't Know" responses not shown. CHW = Community Health Worker.
SOURCE : Kaiser Family Foundation Survey of Medicaid Managed Care Plans, 2017.

Peer Support and CHWs

Medicaid regulations permit states to reimburse non-licensed providers for providing preventive services, as long as the services are "recommended by" a licensed provider. This provision would permit states to reimburse community health workers, peer navigators, or similar support workers engaged in the provision of PrEP. To make this change, states would need to submit a state plan amendment to CMS detailing the types of services and providers they propose to reimburse. While uptake of this provision for any kind of preventive service has been limited, Medicaid agency and public health officials could explore whether an amendment to cover non-licensed support providers who offer PrEP would be feasible. If a state implements this option, community health workers (CHWs) could potentially bill for PrEP support services under "Self management education and training"; in some states, CHWs could potentially also be reimbursed for Targeted Case Management (see prior section).[84] States could develop specific protocols indicating the amount, scope, and duration of PrEP case management services to be covered.[85]

State Medicaid agencies could work with other stakeholders to identify existing policies regarding reimbursement of peer support services, and discuss potential reimbursement of PrEP peer supports, navigators, or case managers.

Other MCO Care Coordination Strategies

MCOs can provide care coordination services beyond what's included in a state plan or waivers, at times motivated simply by the identification of a need among their enrollees.[86] This may include types of care coordination applicable to PrEP. Currently, as shown in Figure 2, most Medicaid MCOs report using a range of strategies to promote coordinated care[87]:

MCOs could work with other PrEP stakeholders to determine whether and how care coordination for PrEP could be integrated into existing or emerging strategies, for example by including PrEP users as eligible for care coordination services. Partners for such coordination services could include local health departments or CBOs, or those entities could provide training on PrEP to current care coordination providers. MCOs could also consider directly paying for additional staffing at provider facilities with high numbers of enrollees who are PrEP users to conduct care coordination.

To the extent a Medicaid MCO pays for services that go beyond the state's Medicaid benefit package, the MCO must use administrative rather than medical services funds. Regardless, MCOs may be motivated to provide these services to improve their enrollees' health. In addition, quality improvement activities such as care coordination for PrEP, can count toward the numerator of a plan's "medical loss ratio" or MLR. The MLR reflects the proportion of total capitated payments received that are spent on clinical claims and quality improvement. Medicaid MCOs must meet a minimum 85 percent MLR, with most states requiring plans to remit funds to the state if the ratio is not met. Therefore, the inclusion of quality improvement in MLR offers plans an incentive to invest in the kinds of coordination and navigation activities that could support PrEP clinical services.

Table 3: Potential Practice Quality Measures from CDC PrEP Clinical Providers' Supplement, 2017

Quality Indicator	Eligible Population	Numerator	Denominator
HIV testing, baseline medication	All persons prescribed PrEP medication	Number of patients with negative HIV test result documented within 1 week prior to initial prescription of PrEP	Number of persons prescribed PrEP
HIV testing, interval	All persons prescribed PrEP medications	Number of PrEP patients with an HIV test result documented at least every 3 months while PrEP medication prescribed	Number of persons prescribed PrEP for >3 months continuously
PrEP medication adherence	All persons prescribed PrEP medications	Number of PrEP patients with adherence assessment noted in the medical record for any visits when prescribed PrEP medication	Number of persons prescribed PrEP medication
Seroconversion	All persons prescribed PrEP medications	Number of patients with a confirmed HIV positive test result while PrEP medications prescribed	Number of persons prescribed PrEP medication for >1 month
Seroconversion, resistant virus	All persons prescribed PrEP medication who received a genotypic resistance test within 4 weeks after an HIV positive test result	Number of persons seroconverting while taking PrEP who have resistant virus detected by genotypic test	Number of persons prescribed PrEP medication who received a genotypic resistance test within 4 weeks after a confirmed HIV positive test result

Coding and Billing for PrEP

NASTAD has prepared a detailed guide for providers seeking to bill Medicaid and other payers for PrEP clinical services.[88] The guide details procedure codes and diagnosis codes for billing key elements of the intervention, including:

- A medical office visit for PrEP initiation;
- Shared medical visits (multiple providers, including at least one physician, APRN, or PA);
- Preventive medicine counseling and/or risk factor reduction intervention, individual or group;
- Labs for PrEP initiation and ongoing monitoring;
- PrEP adherence counseling; and
- High intensity behavioral counseling to prevent STIs.

As discussed in the guide, state Medicaid programs differ in their requirements as to who can provide each service. For example, some permit certain services to be provided by a non-licensed staff number "under the supervision of" a physician, APRN, or PA.

The U.S. Preventive Services Task Force and PrEP

In November 2018, the USPSTF issued a draft "Grade A" recommendation for PrEP for HIV.[89] If finalized, this recommendation would trigger statutory coverage requirements that the recommended service be covered without cost-sharing by nearly all private issuers, as well as for Medicaid expansion enrollees. In addition, such a recommendation could enhance overall provider engagement efforts with regard to PrEP. It remains to be seen whether the USPSTF recommendation, if finalized, will explicitly include HIV and STI testing and the other PrEP clinical services in a way that translates into clear coverage requirements for those clinical services.

Performance Improvement

In the Medicaid program, the quality of care covered by MCOs and delivered by providers can be addressed through performance incentives at various levels. This section discusses incentives for improving PrEP care at the plan level, incentives that states can offer providers directly by the state FFS program, and approaches that MCOs apply to reward performance for providers in their networks.

At any level, using performance measures to improve PrEP care requires valid measures. The CDC's 2017 PrEP guidelines include five "Potential Practice Quality Measures" (see Table 3).[90] While none have been tested and validated according to commonly endorsed standards, eventually they – or other nationally developed or state-specific measures – could be used to evaluate the performance of providers and MCOs in offering PrEP medication and clinical services. As an interviewee noted, any discussion of metrics for PrEP clinical services must take place in a broader discussion about PrEP metrics overall, and perhaps incorporate risk adjustments to reflect populations that may be more difficult to reach and retain with consistent PrEP services.[91]

Incentives for Plan-Level Quality Improvement

State Medicaid agencies could build specific incentives into their contracts with MCOs to stimulate the provision of recommended services.[92] In FY17, the majority of managed care states reported using one or more quality improvement approaches for MCOs: 22 used "pay for performance" bonuses for reaching certain performance thresholds; 29 used "capitation withholds" or penalties for plans *not* meeting performance thresholds; and 36 required data collection and reporting for quality improvement.[93] More states were planning new or expanded quality improvement initiatives. For example, Michigan's "Bonus Template" for Medicaid MCOs involves a total funding withhold; plans can recover 'bonus dollars' for meeting state-set performance goals in areas of population health, health equity, access to care, and community collaboration.[94] Tennessee's pay for performance program gives MCOs an additional per member, per month payment when they meet HEDIS performance thresholds, with measures selected by each MCO from among a set of state-identified options.[95] While no PrEP-specific performance-based contract provisions were identified in research or interviews, they could be developed and applied.

In addition to financial incentives to MCOs, states can reward high-performing plans with priority for auto-assignment of enrollees who do not select a plan themselves.[96] A PrEP measure could be integrated into auto-assignment preferences as well.

States can also require Medicaid MCOs to engage in specific targeted Performance Improvement Projects, or PIPs. A PIP around PrEP coverage and engagement could give MCOs an opportunity, on their own and collaboratively, to closely examine the quality of care and coverage they are providing PrEP users and identify necessary changes.

Medicaid agencies could work with public health officials to identify whether existing MCO quality improvement initiatives could integrate PrEP care. Often, plans are assessed based on HEDIS performance measures, a standard set of plan quality metrics, which do not currently include any PrEP measures. States are not bound by HEDIS or NCQA-approved measures[97]; they could develop their own metrics around PrEP, and pilot models based on them.[98] However, plans (and providers) may be more likely to resist relatively novel metrics, particularly if linked to penalties or incentives. In addition, states would need to be persuaded that PrEP is a significant enough issue to merit the intensive and complex negotiations around performance measures in MCO contracts.

State Medicaid Agency Direct Financial Incentives to Providers

In states with significant fee-for-service enrollment, state Medicaid agencies could undertake a range of financing policies to directly influence provider behavior regarding PrEP.

One approach is to offer incentives for providers who meet certain standards. Linking incentives to performance would require reliable performance measures linked to PrEP medication and clinical services.

Notably, performance measures could face opposition from providers, who are working with many performance measures and incentive systems across a broad range of health issues. In addition, the relatively small number of PrEP users in any given provider's panel could render performance data unreliable.

While clinic-based quality measures for PrEP services may be a goal, an initial interim step in some contexts could be linking financial incentives to more easily measured provider behavior such as participation in training or academic detailing on PrEP, or in trainings on bias and patient engagement related to PrEP and other sexual health services.

Medicaid agencies and public health officials could identify any existing provider incentive initiatives in their states' FFS programs and determine if PrEP medication and clinical services could be integrated into the model.

MCO Provider Payment Models

Most MCOs pay at least some providers on a fee-for-service basis. However, in nearly all states, MCOs are also using various alternative payment models.[99] In FY17, 93 percent of plans surveyed reporting using "pay for performance" for providers, 38 percent reported using bundled payments and 44 percent reported using other shared-savings or shared risk arrangements.[100]

Pay for Performance

Like state FFS programs, MCOs can create incentives linking provider payments to meeting certain standards of performance. As discussed above, this approach for PrEP, as well as for PrEP clinical services, would depend on the development of performance measures acceptable to both plans and providers. The feasibility would also depend on whether the relevant performance information could be gleaned from claims data, or whether it would require information from medical records or other sources. Offering payment incentives for appropriate provision of PrEP clinical services could be tailored to specific specialties (e.g. infectious disease, internal medicine, or family practice) within an MCO's network.

Bundled Payments

The term "bundled payments" does not have a single meaning in payment policy – rather, it can be used in different contexts to describe a broad range of payment types, including:

- A single payment for a particular type of office visit;
- An "episode-based" payment, such as paying a health system for a patient's knee surgery and all related services prior and in followup to it; and
- "Global" payments (e.g. per member, per month (PM/PM) to a group or system in return for providing a certain type of care). This is sometimes referred to as "subcapitation."

One PrEP provider interviewed stated that a per-visit bundled rate from Medicaid MCOs for PrEP would be ideal, but anticipated that in most cases providers will have to continue to get as much as possible out a standardly-reimbursed visit.[101] It is also important to note that in much of the literature, the "success" of bundled payments is discussed in terms of financial savings, though measures are typically put in place to maintain quality.[102] PrEP stakeholders should therefore consider both the feasibility and value of pursuing bundled MCO payments to providers for PrEP.

Shared Savings or Shared-Risk Models

Shared savings models are structured in a way that allows providers to benefit if the quality of patient services yields savings; shared-risk models can also include providers' accepting "downside" risk if costs are higher than anticipated. Overall, many practices may not be ready to engage in risk-sharing, particularly down-side risk, for PrEP or for care provision in general. In addition, PrEP may not generate enough costs, or savings, to rise to the level of warranting a shared savings model.

Access to PrEP Providers

Patients can only access PrEP medication and clinical care if they have access to care providers.

States with significant FFS enrollment should work with public health stakeholders and providers to ensure that PrEP providers are participating in the program and accepting new Medicaid patients. If not, they should work to identify barriers and potential solutions.

Comprehensive Medicaid MCOs contract with a specific network of providers – including clinicians, health care facilities, and laboratories – to provide care to their enrollees. Generally, a provider must be part of a specific MCO's network to receive reimbursement for services provided to that MCO's enrollees.

Current federal law and regulations require states that use managed care to develop "network adequacy" standards for certain provider categories, which are not PrEP- or HIV-specific.[103] However, states can choose to develop further standards; in theory, a state Medicaid agency could by contract require MCOs in the state to include PrEP providers in their network.

MCOs can also go further to ensure that their networks meet the needs of their enrollees. In addition to considering statewide PrEP network adequacy standards, MCOs could work with public health stakeholders to evaluate their networks and identify PrEP providers to meet their members' HIV prevention needs.

Lessons from MCO Support of Medication-Assisted Treatment for Opioid Addiction

A recent report for the Association for Community Health Plans detailed the strategies that several Medicaid MCOs are using to support and engage primary care physicians in prescribing Medication-Assisted Treatment (MAT) for opioid use disorder.[151] Like PrEP, MAT is an evidence-based tool that has been underutilized within Medicaid programs and more generally. However, MAT has taken on increased urgency because of the national opioid epidemic, and the ways MCOs have approached its scaleup could help inform PrEP efforts.

The authors of the report identified provider barriers that in several ways echo those involved with PrEP: a lack of provider education; the additional management burden of MAT practice; and stigma related to the patient population and to the underlying risk behavior.[152]

MCOs profiled in the report used a variety of approaches to engage new MAT providers and to support and maintain existing providers. Examples of strategies that used financial incentives include the following:

- UPMC (Pa.) offers performance-based payments for providers who meet multiple MAT-related quality indicators. The payments can be used to hire social workers or nurse care managers, or to otherwise strengthen treatment services.
- Inland Empire Health Plan (Calif.) will be including payment for out of office MAT training time in its provider contracts.
- Partnership Health Plan (Calif.) gives financial incentives to primary care providers who are willing to take MAT referrals and conduct specific monitoring activities.
- Geisinger Health Plan (Pa.) provides bundled payment for MAT prescribers to reduce provider administrative burden. The payment is a per member, per month amount that includes an initial visit; initiation of MAT, stabilization, and maintenance (drugs are reimbursed separately). Providers send a weekly list of MAT patients to the plan; the model does not currently include quality requirements, but Geisinger is considering their inclusion.[153]

The existing website https://preplocator.org is a searchable directory of clinics and providers who offer PrEP. It is not exhaustive – relying on direct submissions or confirmations from providers – but could inform first steps in determining an MCO's network adequacy with regard to PrEP. Such efforts could be paired with ensuring that MCO networks includes STI clinics, other public health clinics, and infectious disease doctors, thereby reaching a slate of providers who may be more likely to offer PrEP services.

Partnerships with Local Health Departments and Community-Based Organizations

Local health departments (LHDs) or CBOs could, in some cases, serve as quality providers of PrEP clinical services or support services. Public health stakeholders could, through a formal "certification" or informally, help identify public or community-based entities in the region that are qualified to support PrEP users and providers.

This section describes how state Medicaid agencies could support LHD and CBO engagement in PrEP directly or by encouraging or requiring MCO engagement, as well as how MCOs could support LHD and CBO engagement.

State Medicaid Agencies Directly Supporting Local Health Departments or CBOs

State Medicaid agencies could reimburse local health department STD or primary care clinics or community-based providers that offer PrEP and/or PrEP clinical services for Medicaid enrollees.

Health-department-run clinics, including STD clinics, are important sites for initiating PrEP medication and clinical services or, for some clinics, maintaining patients on PrEP. Health department clinics that do not currently have or intend to have the capacity to initiate or deliver PrEP also serve a crucial role in actively referring patients to providers in the community.

A 2015 survey from NACCHO (National Association of County and City Health Officials) of local health departments (LHDs) that provide or contract out HIV or STI screenings found that almost one third were engaged in some way in PrEP. Those that directly provided services or ran STD clinics were more likely to be engaged in PrEP.[104] "Engagement" varied, with 74 percent making referrals to PrEP providers, and only 9 percent delivering PrEP, though almost a third of LHDs who were at all engaged with PrEP saw direct provision as an "optimal" role for LHDs.[105] While these figures may have increased in the intervening years, one interviewee reported that an increasing number of LHDs see their role as initiating patients on PrEP and working to transition them to other primary care providers, if that is an option.[106]

When LHDs do engage in providing PrEP medication, clinical care, and support services, Medicaid might not always be billed. The NACCHO survey found that only 47 percent of respondent LHDs – all of which were directly providing STI or HIV services – reported billing Medicaid at all.[107] In some states, public STD clinics are legally prohibited from billing insurance, including Medicaid.[108] When asked if their state Medicaid program pays for PrEP, 75 percent of respondents in the NACCHO survey selected "Don't know."[109]

These data are consistent with a concern expressed by a member of the steering committee that public clinics may be serving PrEP patients without receiving reimbursement, even when those patients have Medicaid coverage.[110] This could be due to a range of factors, including confidentiality concerns (particularly for adolescents or young adolescents who share an address with their parents), or visits being conducted by nonbillable providers (e.g. RNs). In addition to being a non-optimal use of health department funds, this potential pattern could make it difficult to identify problems when billing Medicaid for STI services because Medicaid is not, in fact, being billed (for PrEP or for any services). A further concern is a potential lack of coordination/communication between providers offering different components of the PrEP service suite.

Stakeholders could explore whether Medicaid reimbursement for LHD provision of PrEP and related clinical care is being maximized within the parameters of their state's laws and payment policies. Within this assessment, stakeholders could also determine if eligible public primary care or STD clinics in the state are in fact participating in the 340B program, which requires Medicaid-participating pharmaceutical manufacturers to offer deep discounts on drugs to certain categories of registered safety net providers, including STD clinics.[111]

For non-clinical CBOs, State Medicaid agencies could develop contracts or agreements to offer PrEP support services. Because support of non-clinical CBOs is not a traditional role for Medicaid in all states, public health agencies can help identify opportunities for this engagement.

MCO Collaboration with LHDs or CBOs

On the managed care side, MCOs could also establish contracts or memoranda of understanding (MOUs) with local health departments to offer PrEP medication and/or clinical services to enrollees. MCOs may undertake such actions based on their members' needs; stakeholders could also explore whether current state MCO contract language could encourage or require MCOs to engage with LHDs and CBOs, for PrEP or more broadly.

In addition to reimbursing LHDs for clinical care, MCOs also have the flexibility to consider more novel ways of incorporating LHD services into PrEP care. For example, Medicaid MCOs could help support Disease Intervention Specialists (DIS), funding them in a way comparable to CHWs, to serve the STI tracking and care coordination needs of their enrollees. This approach would extend beyond PrEP, and involve engaging MCOs in understanding the benefits of LHD and DIS involvement with STIs for their communities' health and their financial bottom line.

MCOs could also work with non-clinical CBOs to support PrEP users. For example, in a model that could be considered for PrEP support, AIDS Foundation of Chicago (AFC) contracts with two Medicaid MCOs. Under the "Reach and Engage" service package, AFC conducts outreach to members deemed "unable to locate" to connect and re-engage them with primary care providers.[112] One MCO pays a flat monthly rate; another pays on a PM/PM basis. Members assigned to AFC include some who are HIV-positive as well as others who are at high risk of HIV. This type of model could be useful in the PrEP arena; for example, a non-clinical CBO could propose to work with MCOs to support various parts of PrEP, such as linking PrEP users to a range of clinical services.

AIDS United has developed a set of webinars and resources to support CBOs in approaching MCOs.[113] The Association for Community Affiliated Plans also has multiple resources, including a factsheet highlighting of range of examples of Medicaid MCO partnerships with local organizations.[114]

MCOs can similarly engage with community health workers, on their own initiative or under a state contractual requirement. For example, Michigan's Medicaid MCOs are required by contract to support CHWs.[115] Priority Health, a Medicaid MCO and integrated delivery system, employs CHWs and additionally contracts with a vendor to directly address enrollee needs in a specific portion of the state.[116] CHWs both within and outside the plan help identify and address enrollees' social determinants of health.[117] Medicaid agencies and MCOs could work with public health agencies to explore supporting qualified CHWs as PrEP navigators.

Specific Considerations Linked to Provider Type and Setting

PrEP scaleup may in many contexts rely on the engagement of providers other than physicians, and settings other than a traditional clinical setting. This section reviews certain considerations related to Medicaid reimbursement for non-physician providers, as well as issues related to pharmacy reimbursement, federally-qualified health centers and rural health centers.

Nurse Practitioners and Physician Assistants

Within a given state, engagement of nurse practitioners (NPs) and physician assistants (PAs) in PrEP would depend on both scope of practice and reimbursement. Scope of practice issues are not specific to Medicaid, but Medicaid and public health stakeholders need to understand the opportunities and limitations for these providers at the state level. In 26 states, NPs have prescribing authority only within the bounds of a relationship with a physician; in 11 states NPs must complete a transition period toward full prescribing authority; and in 13 states plus DC, NPs have full prescribing authority (see www.scopeofpracticepolicy.org for details by state).[118] For PAs, who generally work with a supervising physician, in most states prescriptive authority is determined by agreement between the PA and that physician.[119]

Nurse practitioner (NP) visits can be billed to Medicaid[120] as long as services provided are within the state's scope of practice laws. State FFS programs generally reimburse NPs at between 75 and 100 percent of the physician reimbursement rate.[121] A NP interviewed stated that she generally bills her PrEP visits as a Level 3 established office visit, which allows for counseling and risk reduction.[122]

All Medicaid programs offer reimbursement for services provided by Physician Assistants operating within their scope of practice, but in some states reimbursement may be through the supervising physician. The rate may be lower than that paid for services provided by physicians or the same, depending on the state.[123]

Services Provided by Registered Nurses

As noted by one infectious disease doctor interviewed for this project, one way to reduce the burden of repeated STI testing on prescribers would be to task-shift the testing to RNs.[124] Jason Farley, a PrEP provider and researcher and the immediate-past President of the Association of Nurses in AIDS Care, maintains that non-prescribing RNs could in fact run a PrEP clinic under standing orders, with the nurse conducting clinical monitoring and the patient self-swabbing for STIs.[125] In this model, a prescribing provider could be consulted for specific cases such as seroconversion, nonadherence, or a diagnosed STI in need of treatment. Lyn Stevens of New York State's Department of Health echoed the belief that some ongoing PrEP services and visits could be conducted by RNs.[126]

However, multiple interviewees noted that visits with *only* a registered nurse are not reimbursable in their specific settings.[127] Reimbursement of RN visits should be assessed at the state level to determine what PrEP clinical services can be supported under this model.

Pharmacies and Pharmacists

Pharmacies and pharmacists can play key roles not only in dispensing PrEP medication but also in supporting adherence to PrEP and to PrEP clinical services through various models.

In pharmacies with clinics that employ health care providers with prescribing authority, providing PrEP is relatively straightforward. For example, at certain Walgreens sites, health care clinic providers are able to prescribe PrEP, along with conducting STI and HIV screenings.[128]

Pharmacists may also be able to provide most or all PrEP services directly, depending on the practice arrangements permitted under state law. For example, in Seattle, the Kelley-Ross Pharmacy runs a "One-Step PrEP" clinic under a collaborative drug therapy agreement.[129] Pharmacists conduct initial meetings, sexual histories, lab testing, and education, in addition to dispensing medication.[130] An estimated 20 percent of the clinic's PrEP patients are Medicaid enrollees, most enrolled in MCOs. The pharmacists can bill visits on the same terms as other providers based on level of service, and can conduct all necessary lab testing with Medicaid reimbursement.[131]

In Iowa, collaborative practice agreements between MDs and PharmDs allow the pharmacists to provide expanded PrEP services.[132] Providers conduct an initial PrEP visit through either telehealth or an LGBTQ+ clinic, and pharmacists do monitoring and follow-up visits.[133]

For pharmacies acting within more traditional bounds of practice, Medicaid reimburses for drugs and pays pharmacists a small dispensing fee. However, in some states, Medicaid will reimburse pharmacists for enhanced medication therapy management, or MTM services.[134] In theory, MTM eligibility could be extended to persons on PrEP and include enhanced counseling and reminders about renewals.

Stakeholders could explore their states' pharmacist practice agreements and Medicaid financing models for pharmacies, including whether their state Medicaid program has an MTM model that could be applied to pharmacist engagement in PrEP.

Federally-Qualified Health Centers and Rural Health Centers

As community-based providers of comprehensive and coordinated primary care services,[135] federally-qualified health centers (FQHCs) should be an important locus for the provision of PrEP medication and clinical services. FQHCs receive federal funding from the Bureau of Primary Health Care within HRSA to offer care; they serve both uninsured and insured patients, including Medicaid enrollees. FQHCs' unique Medicaid reimbursement structure creates both opportunities and challenges for provision of PrEP medication and clinical services.

Under federal law, state Medicaid programs pay FQHCs under a prospective payment system (PPS), using a set, per-visit rate based either on cost reporting or on local averages.[136] This per-visit rate includes all services provided during a visit with a licensed provider, encompassing not only the primary encounter but, for example, any nurse or lab services provided in the visit. Some states have "unbundled" certain services from the PPS rate in order to incentivize their provision; for example, some states reimburse FQHCs the actual acquisition costs for long-acting reversible contraceptives, on top of the PPS rate.[137]

Medicaid MCOs are not required under federal law to pay FQHCs the PPS rate, but must pay at least what they would pay a non-FQHC provider for the same services. However, FQHCs must *receive*, in the aggregate, at least the amount they would have earned under the PPS payment. Therefore, states must make "wrap-around" payments to FQHCs if the MCO reimbursement is in fact lower, in the aggregate, than the PPS.

Under federal law, similar Medicaid payment provisions apply to Rural Health Centers, which are certain facilities in "nonurbanized," underserved areas.[138]

Whitman-Walker Health, an FQHC in Washington DC, provides PrEP intervention services to approximately 2,000 people, an estimated 30-35 percent of whom are Medicaid enrollees.[139] As an FQHC, Whitman-Walker serves many vulnerable patients, requiring wraparound care to meet patients' health needs. Therefore, the cost reporting on which the clinic's PPS rate is based includes not only clinical services but also support services, including such as care navigator and retention manager. The resulting enhanced rate, higher than the typical commercial reimbursement Whitman-Walker receives for the clinical services only, still falls short of covering all PrEP-related services the clinic offers. Importantly, FQHC reimbursement rates can vary by state and by facility.[140] Because PPS rates are only negotiated every few years, they are often not reflective of current year expenses, and may not reflect the costs of emerging technologies or newer services like PrEP.

Whitman-Walker has been able to establish a specific PrEP clinic which to date has seen approximately 200 of their PrEP patients. The patients see both a nurse and phlebotomist in a brief visit to streamline their receipt of PrEP clinical services. These patients do not otherwise come to the center frequently for other medical care (though the patients do see a clinical provider at least once per year, for annual wellness visits, per 340B program requirements). Other

than the lab work, the visits are not reimbursable by Medicaid or other insurance because the patients do not see a Medicaid-reimbursable clinical provider in this visit. However, Whitman-Walker reports that it is worth it to use clinic funds to support this immediate PrEP access option so that this subset of patients receive PrEP adherence support and STI testing on demand.[141]

FQHCs, like STD clinics, are eligible for the 340B drug pricing program. An FQHC with its own pharmacy, or that contracts with pharmacies in the community under 340B, can buy drugs at the 340B discounted rate.

Stakeholders can work to promote provision of PrEP medication and clinical services at FQHCs, at the local, state, and federal levels. Locally, public health agencies can determine if FQHCs are providing PrEP and work to identify barriers, including those related to Medicaid reimbursement. At the state level, the Medicaid agency can work with public health stakeholders to analyze FQHC reimbursement and whether modifications can be made to adequately support PrEP medication and clinical services. Federally, HRSA can work with CMS and the CDC to identify opportunities, such as developing ongoing training opportunities or clinical practice resources for FQHC staff. While these queries and approaches focus on the Medicaid lens, they could serve to identify broader barriers and opportunities to PrEP at FQHCs.

Further Considerations for Medicaid Benefits and Financing

A number of additional opportunities and challenges should be considered at the state level to help optimize Medicaid support of PrEP intervention services.

Leveraging Medicaid Data to Increase Access

Multiple interviewees agreed that Medicaid claim data should be leveraged to improve provision of PrEP clinical services to current PrEP users, as well as to increase PrEP uptake and adherence. Because Medicaid agencies do not always have staffing or resources to spare for new analyses,[142] public health stakeholders may need to develop or expand existing data sharing agreements with state Medicaid agencies, or work together to identify a third party that could conduct the analyses. [143]

For benefit design and financing purposes, Medicaid claims data could potentially be used in at least three ways:

- Identifying the current rate of PrEP use in the Medicaid program, including stratification by certain populations, to help optimize how the benefit is structured and financed;
- Tracking the provision of clinical services to current PrEP users, in part to inform calculations of value, potentially for value-based payment approaches; and
- Identifying candidates for PrEP, based on STI-related claims or other indicators from Medicaid data, to consider the potential impact of broad, population-based models for improving PrEP coverage and uptake.

Developing an ROI for PrEP

Multiple experts on the steering committee noted the importance of developing return on investment (ROI) data on PrEP to help inform benefit and financing discussions among State Medicaid agencies, MCOs, and other PrEP stakeholders.

ROI can be conceptualized at two levels: the ROI for PrEP overall, and the marginal ROI for optimal PrEP care that includes all recommended clinical services. The former is important for consideration of overall PrEP uptake; the latter may be useful in promoting policy changes to specifically ensure that Medicaid programs and MCOs are covering STI labs and other clinical PrEP services. In addition, information about the likely timeline in which ROI would be realized would help Medicaid agencies and MCOs understand if they are likely to see the savings themselves.

An important factor to consider in PrEP ROI is that a high proportion of PrEP users are likely to be "expansion enrollees" for whom the vast majority of Medicaid costs are borne by the federal government. For these adults, the federal government pays an FMAP starting at 100 percent and ramping down to 90 percent. For most states, this is far higher than the usual FMAP. Therefore, from the state perspective, the marginal costs of PrEP medication and clinical services are likely to be heavily discounted for expansion enrollees.[144] Of course, any financial savings from PrEP would be similarly discounted for the state.

MCOs, receiving fixed rates from the state per enrollee, would also be concerned about ROI. In states where one issuer dominates the Medicaid MCO market, cost-effectiveness arguments might be particularly effective because that issuer is more likely to see any savings achieved.[145] As noted above, in states where pharmacy or HIV drugs are carved out of MCO contracts, the ROI for PrEP would be less relevant for MCOs.

The financial ROI for PrEP may evolve over time, both as generics becomes available and as more information emerges regarding intermittent use models.

Conclusion

The Medicaid program is complex, offering a broad range of both challenges and opportunities for delivery of PrEP medication and clinical services. The levers and examples discussed in this white paper, along with the accompanying paper on Medicaid patient and provider engagement, should serve as a starting point for conversations about how Medicaid agencies and MCOs can work with public health to increase access, reduce HIV transmission, and promote the health of PrEP users.

Appendix 1: Project Steering Committee

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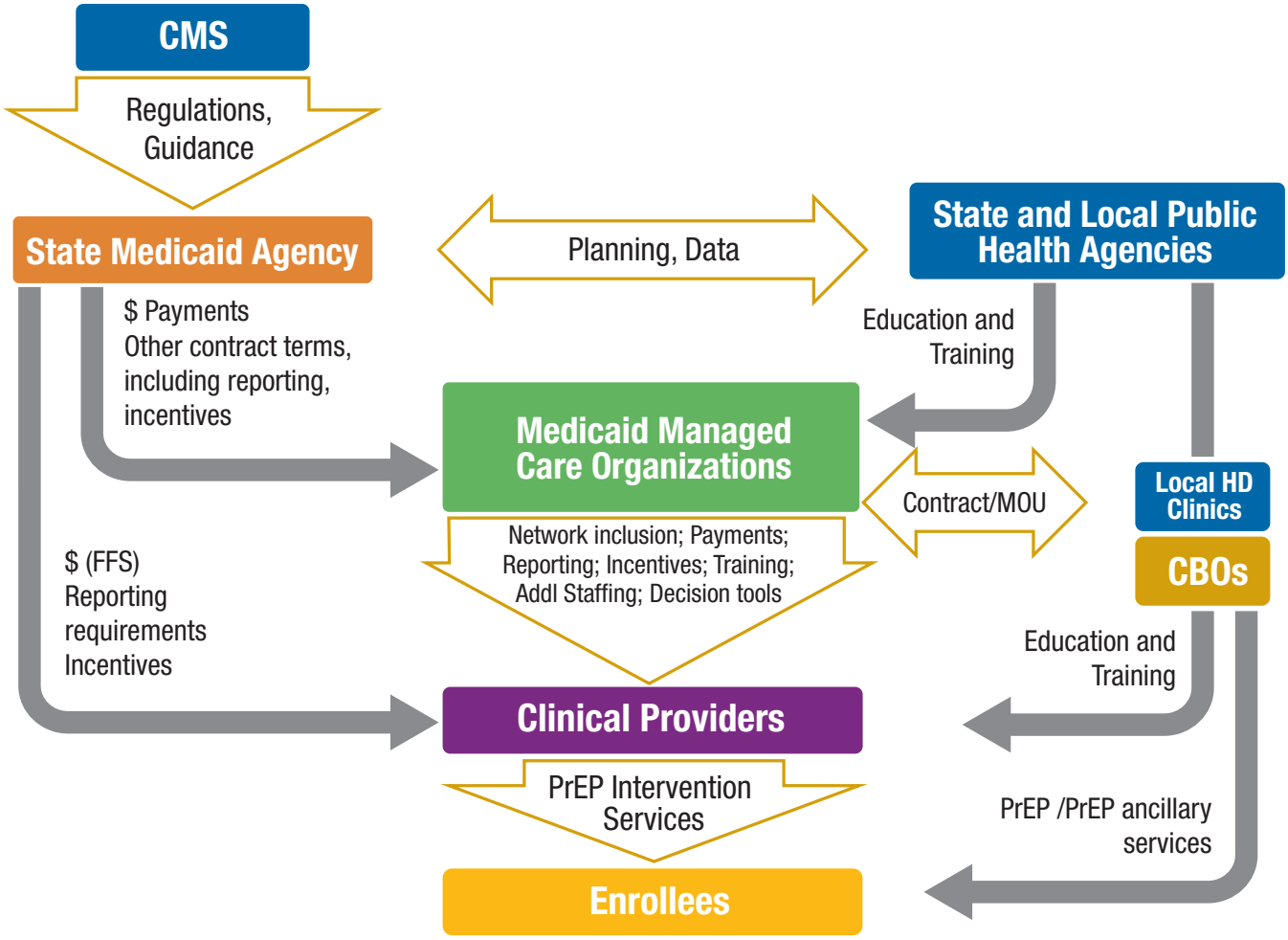
Appendix 2: Schematic of Medicaid Financing Levers



Endnotes

1. Siegler AJ, et al., The prevalence of pre-exposure prophylaxis use and the pre-exposure prophylaxiseto-need ratio in the fourth quarter of 2017, United States, Annals of Epidemiology (2018), https://doi.org/10.1016/j.annepi
2. CDC, "HIV prevention pill not reaching most Americans who could benefit – especially people of color" (Mar. 2018). www.cdc.gov/nchhstp/newsroom/
3. See, e.g., California HIV/AIDS Research Program, "Addressing PrEP Disparities Among Young Gay and Bisexual Men in California" (Sep. 2016). https://
4. Goldstein et al., "Being PrEPared — Preexposure Prophylaxis and HIV Disparities." New England Journal of Medicine (Sept. 19, 2018). www.nejm.org/doi/
5. AIDSMAP, "PrEP use growing in US, but not reaching all those in need" (Mar. 7, 2018). www.aidsmap.com/PrEP-use-growing-in-US-but-not-reaching-all-
6. See, e.g., Matthew A Spinelli, Hyman M Scott, Eric Vittinghoff, Albert Y Liu, Alicia Morehead-Gee, Rafael Gonzalez, Susan P Buchbinder; Provider Adherence to Pre-exposure Prophylaxis Monitoring Guidelines in a Large Primary Care Network, *Open Forum Infectious Diseases*, Volume 5, Issue 6, 1 June 2018, ofy099, https://doi.org/10.1093/ofid/ofy099
7. CDC, "PrEP" (Updated Aug. 23, 2018). www.cdc.gov/hiv/basics/prep.html
8. ANDA Approval Letter from FDA to Teva Pharmaceuticals USA, Inc. (June 8, 2017). www.accessdata.fda.gov/drugsatfda_docs/appletter/2017/090894Orig1s
9. ANDA Approval Letter from FDA to Amneal Pharmaceuticals of NY (Aug. 22, 2018). www.accessdata.fda.gov/drugsatfda_docs/appletter/2018/209721Orig1s
10. CDC, "Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update: A Clinical Practice Guideline." " (Published online Mar. 2018). https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guide
11. Gilead, "Truvada for PrEP Medication Assistance Program." www.gilead.com/responsibility/us-patient-access/truvada%20for%20prep%20medication%20assistance%20program
12. Washington State Department of Health, "Pre-Exposure Prophylaxis Drug Assistance Program (PrEP DAP)." www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/Prevention/PrEPDAP
13. New York State Department of Health, "PrEP Patient Assistance Program (PrEP-AP)." www.health.ny.gov/diseases/aids/general/prep/prep-ap_provider.htm
14. DC Department of Health, "Pre Exposure Prophylaxis Drug Assistance Program (PrEP DAP)." https://dchealth.dc.gov/DCPrEPDAP
15. Kaiser Family Foundation, "Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults" (Mar. 2018). www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/
16. *Id*.
17. Kaiser Family Foundation, "Medicaid Eligibility through the Aged, Blind, Disabled Pathway" (Jan. 2017). Nine states apply state-specific eligibility standards; see www.kff.org/medicaid/state-indicator/medicaid-eligibility-through-the-aged-blind-disabled-pathway/
18. Kaiser Family Foundation, "Health Coverage of Immigrants" (Dec. 2017). www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/
19. Exceptions include certain emergency services for undocumented immigrants. In addition, some states have chosen to use their CHIP programs to cover otherwise ineligible pregnant women who are immigrants.

20. Kaiser Family Foundation, "Current Status of State Medicaid Expansion Decisions" (Jul. 2018). www.kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/
21. MACPAC, "Medicaid enrollment changes following the ACA." www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/. The remaining "non-newly eligible" enrollees were adults who would have been eligible for Medicaid through pre-ACA pathways.
22. Lindsey Dawson, Jennifer Kates, and Anthony Damico, The Affordable Care Act and Insurance Coverage Changes by Sexual Orientation (Washington, DC: Kaiser Family Foundation, January 2018), www.kff.org/disparitiespolicy/issue-
23. McMorrow, Kenney, Long, and Anderson, "Uninsurance Among Young Adults Continues to Decline, Particularly in Medicaid Expansion States," Health Affairs 34, no. 4 (April 2015): 616-620.
24. Kaiser Family Foundation, "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review" (Mar. 2018). www.kff.
25. Coverage of Truvada through a family planning expansion would arguably be *permitted* under federal law, given that PrEP is as "related" to family planning as STI screening and treatment. However, the author did not identify current examples of states including this coverage. California has been asked to add PrEP to its program, but in an August 2017 Family Planning Stakeholder Meeting, explained: "The Family PACT program covers HIV screening only. The request has been presented to the Department before and given the fact that the FPACT program focuses on family PACT planning and family planning related needs, there are no plans to add additional benefits related to HIV beyond screening. Truvada PrEP is an HIV prevention strategy and we do not see it in the realm of family planning. While individuals who come in may be screened for HIV under FPACT, the use of Truvada PrEP is more encompassing and requires periodic monitoring by a provider. Within the scope of sexually transmitted infection testing under FPACT, we do provide very limited services from a prevention/treatment perspective and from the family planning lens; we do not see the use Truvada PrEP as falling into the same category." California Department of Health Care Services, "Family Planning Stakeholder Meeting [powerpoint slides" (Aug. 2017). www.dhcs.ca.gov/services/ofp/Documents/8.22.17PPT_FINAL.pdf.
26. Interview with Laura Beauchamps, August 16, 2018.
27. Kaiser Family Foundation, "States That Have Expanded Eligibility for Coverage of Family Planning Services Under Medicaid" (Jun. 2017). www.kff.org/medicaid/state-indicator/family-planning-services-waivers/
28. Guttmacher Institute, "Medicaid Family Planning Eligibility Expansions" (Updated Sep. 2018). www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions
29. *Id.*
30. Kaiser Family Foundation, "States That Have Expanded Eligibility for Coverage of Family Planning Services Under Medicaid" (Jun. 2017). www.kff.org/medicaid/state-indicator/family-planning-services-waivers/
31. Kaiser Family Foundation, "State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings November 2009" kaiserfamily-foundation.files.wordpress.com/2013/01/8015.pdf
32. *Id.*
33. Kaiser Family Foundation, "Payment and Coverage for the Prevention of Sexually Transmitted Infections (STIs)" (Nov. 2017). www.kff.org/womens-health-policy/fact-sheet/payment-and-coverage-for-the-prevention-of-sexually-transmitted-infections-stis/
34. MACPAC, "Types of Managed Care Arrangements." www.macpac.gov/subtopic/types-of-managed-care-arrangements/
35. 42 CFR 438.206 - Availability of services.
36. Mathematica for CMS, "Medicaid Managed Care Enrollment and Program Characteristics, 2016" (2018). www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2016-medicaid-managed-care-enrollment-report.pdf
37. Kaiser Family Foundation, "Medicaid Managed Care Penetration Rates by Eligibility Group" (Jul., 2017). www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/?activeTab=map
38. *Id.*
39. Kaiser Family Foundation, "Total Medicaid MCOs" (Mar. 2018). www.kff.org/medicaid/state-indicator/total-medicaid-mcos/
40. Kaiser Family Foundation, "Medicaid MCO Enrollment" (Mar. 2018). www.kff.org/other/state-indicator/medicaid-enrollment-by-mco/
41. See, e.g., "CMS Leverages Medicaid Program to Combat the Opioid Crisis" (June 2017). https://www.cms.gov/newsroom/press-releases/cms-leverages-medicaid-program-combat-opioid-crisis
42. CMS, "2018-2019 Medicaid Managed Care Rate Development Guide" (May 2018). www.medicaid.gov/medicaid/managed-care/downloads/guidance/2019-medicaid-rate-guide.pdf
43. MACPAC "Payment Policy in Medicaid Managed Care." *MACPAC Report to Congress* (June 2011). www.macpac.gov/wp-content/uploads/2015/01/Payment_Policy_in_Medicaid_Managed_Care.pdf
44. Mile High Healthcare Analytics, "Risk Adjustment in Medicaid" (2016). www.healthcareanalytics.expert/risk-adjustment-medicaid/
45. Interview with Doug Wirth, September 17, 2018.
46. Interview with David Rzeszutko, August 15, 2018.
47. Kaiser Family Foundation and NAMD, "Medicaid Moving Ahead in October 2017 Uncertain Times Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018" (Oct. 2017). http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018. Most commonly "carved out" benefits are behavioral health benefits, though there is a trend in behavioral health toward states "carving back in" some such services.
48. *Id.*
49. Interview with Mike Wofford, August 30, 2018.
50. Michigan Association of Community Mental Health Boards, "Membership: PIHP." https://macmhb.org/membership/pihp
51. Interview with David Rzeszutko, August 15, 2018.
52. Kaiser Family Foundation, "Share of Medicaid Population Covered under Different Delivery Systems" (Jul. 2017). www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/
53. American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA), "Joint Principles of the Patient-Centered Medical Home" (2007). www.acponline.org/system/files/documents/running_practice/delivery_and_payment_models/pcmh/demonstrations/jointprinc_05_17.pdf
54. Kaiser Family Foundation, "States that Reported Patient Centered Medical Homes In Place (SFY 2015-2017)." www.kff.org/medicaid/state-indicator/states-that-reported-patient-centered-medical-homes-in-place/
55. For the first two years, states received an enhanced 90% federal match for these six services; states then have considerable flexibility in how they pay health home providers, with most using a per member/per month rate.
56. CMS, "State-by-State Health Home State Plan Amendment Matrix" (Updated Apr. 2018). www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/state-hh-spa.pdf
57. Center for Health Care Strategies, "Medicaid Accountable Care Organizations: State Update" (Feb. 2018). www.chcs.org/media/ACO-Fact-Sheet-02-27-2018-1.pdf
58. *Id.*
59. AcademyHealth interview with Doug Wirth, June 11, 2018.
60. CMS, "Accountable Health Communities Model." innovation.cms.gov/initiatives/ahcm/
61. National Academy for State Health Policy, "State Levers to Advance Accountable Communities for Health" (May 2016). nashp.org/state-levers-to-advance-accountable-communities-for-health/
62. 42 CFR 438.206 - Availability of services.
63. HealthHIV, "Assessment of Medicaid Coverage of HIV/AIDS Prevention,

Screening, and Care Services: A Ten-State Review" (2015). targethiv.org/sites/default/files/file-upload/resources/HealthHIV%20Medicaid%20Prevention%20Care%20Assessment%202016.pdf

64. Interview with Mike Wofford and Sandra Robinson, August 31, 2018.
65. AcademyHealth Interview with DeAnn Gruber, May 23, 2018.
66. Medicaid.gov, "Telemedicine." www.medicaid.gov/medicaid/benefits/telemed/index.html
67. Center for Connected Health Policy, "50 State Scan of Telehealth Reimbursement Laws and Medicaid Policies – Factsheet" (2018). www.cchpca.org/sites/default/files/resources/50%20State%20Factsheet%20Spring%202018%20FI
68. *Id.*
69. Kaiser Family Foundation, Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans" (Mar. 2018). www.kff.org/report-section/medicaid-managed-care-plans-and-access-to-care-provider-networks-and-access-to-care/
70 Peter Wehrwein, "Q&A: A Interview with Henry DePhillips, MD: The Doctor in the Teladoc House" (April 2017). www.managedcaremag.com/archives/2017/4/Interview-henry-dephillips-md-doctor-teladoc-house
71. See www.nurx.com/prep and https://prep.plushcare.com.
72. Responses to AcademyHealth survey, October 2018.
73. See, e.g., New York State's Medicaid PA requirement for Truvada at https://newyork.fhsc.com/providers/CDRP_truvada.asp; interviewees from the state did not cite this requirement as a barrier to access.
74. Doug Wirth, Steering Committee Kickoff Call, May 9, 2018.
75. Kaiser Family Foundation and NAMD, "Medicaid Moving Ahead in Uncertain Times:Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018" (Oct. 2017). http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018
76. CDC, "Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update: A Clinical Practice Guideline." " (Published online Mar. 2018). https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf
77. Interview with Divya Ahuja, MD, August 9, 2018.
78. Interview with John Carlo, August 22, 2018.
79. AcademyHealth Interview with DeAnn Gruber, May 23, 2018.
80. CDC, "Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update – Clinical Providers' Supplement" (Published online Mar. 2018). www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-provider-supplement-2017.pdf
81. Kaiser Family Foundation, "Medicaid Coverage of Family Planning Benefits: Results From a State Survey" (Sep. 2016). files.kff.org/attachment/Report-Medicaid-Coverage-of-Family-Planning-Benefits-Results-from-a-State-Survey
82. NASTAD, "Financing HIV Prevention Services: Collaboration and Innovation between Public Health and Medicaid Agencies; Case Study: Rhode Island" (Feb. 2016). www.nastad.org/sites/default/files/resources/docs/NASTAD-HIV-Prevention-Rhode-Island-Case-Study.pdf
83. Rhode Island Medicaid, "Provider Reference Manual: Targeted HIV Medicaid Care/Case Management" (Mar. 2017). www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/MA%20Reference%20Guides/HIV%20Providers/HIV_TCM_Manual.pdf
84. NASTAD, "Billing Coding Guide for HIV Prevention: PrEP, Screening, and Linkage Services" (2016). www.nastad.org/resource/billing-coding-guide-hiv-prevention
85. Interview with Sara Rosenbaum, August 14, 2018.
86. Interview with Jennifer Babcock, August 22, 2018.
87. Kaiser Family Foundation "Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans" (Mar. 2018). www.kff.org/report-section/medicaid-managed-care-plans-and-access-to-care-provider-payment-and-delivery-system-reform/
88. NASTAD, "Billing Coding Guide for HIV Prevention: PrEP, Screening, and Linkage Services" (2016). www.nastad.org/resource/billing-coding-guide-hiv-prevention
89. USPSTF, "Draft Recommendation Statement: Prevention of Human Immunodeficiency Virus (HIV) Infection: Pre-Exposure Prophylaxis" (Nov. 2018). https://www.uspreventiveservicestaskforce.org/Page/Document/draft-recommendation-statement/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis
90. CDC, "Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update – Clinical Providers' Supplement" (Published online Mar. 2018). www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-provider-supplement-2017.pdf
91. Interview with Stephen Cha, August 6, 2018.
92. MACPAC "Payment Policy in Medicaid Managed Care." *MACPAC Report to Congress* (June 2011). www.macpac.gov/wp-content/uploads/2015/01/Payment_Policy_in_Medicaid_Managed_Care.pdf
93. Kaiser Family Foundation and NAMD, "Medicaid Moving Ahead in October 2017 Uncertain Times Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018" (Oct. 2017). http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018
94. Interview with David Rzeszutko, August 15, 2018.
95. National Association for State Health Policy, "Tennessee: Using Managed Care Incentivesto Improve Preventive Services and Care for Children" (Jan. 2018). https://nashp.org/wp-content/uploads/2018/01/Tennessee-Case-Study-2018.pdf
96. Kaiser Family Foundation, "Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016" (Oct. 2015). www.kff.org/report-section/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-managed-care-reforms/
97. Interview with Matt Salo, August 20, 2018.
98. Interview with Stephen Cha, August 6, 2018.
99. Kaiser Family Foundation "Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans" (Mar. 2018). (https://www.kff.org/report-section/medicaid-managed-care-plans-and-access-to-care-provider-payment-and-delivery-system-reform/
100. Id.
101. Interview with Dr. John Carlo, August 22, 2018.
102. See, e.g., Delbanco, "The Current Evidence for Bundled Payments" (Apr. 30, 2018). https://www.ajmc.com/contributor/suzanne-delbanco/2018/04/the-current-evidence-for-bundled-payment
103. Kaiser Family Foundation, "CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions" (June 2016). www.kff.org/report-section/cmss-final-rule-on-medicaid-managed-care-issue-brief/
104. Weiss G, Smith DK, Newman S, Wiener J, Kitlas A, Hoover KW (2018) PrEP implementation by local health departments in US cities and counties: Findings from a 2015 assessment of local health departments. PLoS ONE 13(7): e0200338. https://doi.org/10.1371/journal.pone.0200338
105. *Id.*
106. Interview with Gretchen Weiss, August 17, 2018.
107. *Id.*
108. Leichliter JS, Seiler N, Wohlfeiler D. STD Prevention Policies in the United States: Evidence and Opportunities. Sexually transmitted diseases. 2016;43(2 Suppl 1):S113-S121. doi:10.1097/OLQ.0000000000000289. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5283689/
109. Interview with Gretchen Weiss, August 17, 2018.
110. AcademyHealth Interview with Katie Macomber, MI.
111. HRSA, "Sexually Transmitted Disease Clinics." www.hrsa.gov/opa/eligibility-and-registration/specialty-clinics/sexually-transmitted-disease/index.html.
112. NASTAD, "Financing HIV Prevention Services: Collaboration and Innovation between Public Health and Medicaid Agencies: Chicago Case Study" (Feb.

2016). www.nastad.org/sites/default/files/resources/docs/NASTAD-HIV-Prevention-Chicago-Case-Study.pdf

113. AIDS United, "Monetization of HCBO Functions: 6-Part Webinar Series." www.aidsunited.org/webinars/monetization-of-aso-functions-building-a-strong-relationship-with-the-payer-community
114. Association of Community Health Plans, "Partnerships that Strengthen the Safety Net" (2017). www.communityplans.net/wp-content/uploads/2017/06/2017-STSNA-Nominations-Fact-Sheet-FINAL.pdf
115. STATE OF MICHIGAN Contract No.[ ] Comprehensive Health Care Program for the Michigan Department of Health and Human Services. www.michigan.gov/documents/contract_7696_7.pdf
116. Interview with David Rzeszutko, August 15, 2018.
117. *Id.*
118. Scope of Practice Policy, "Nurse Practitioners Overview: Prescriptive Authority." http://scopeofpracticepolicy.org/practitioners/nurse-practitioners/
119. Scope of Practice Policy, "Physician Assistants Overview: Prescriptive Authority." http://scopeofpracticepolicy.org/practitioners/physician-assistants/
120. Kaiser Family Foundation, "Medicaid Benefits: Nurse Practitioner Services" (2012). https://www.kff.org/medicaid/state-indicator/nurse-practitioner-services/
121. *Id.*
122. Interview with Melody Wilkinson, August 22, 2018.
123. American Academy of PAs, "Third-Party Reimbursement for PAs" (Apr. 2018). https://www.aapa.org/wp-content/uploads/2017/01/Third_party_payment_2017_FINAL.pdf
124. Interview with Douglas Krakower, August 8, 2018.
125 Interview with Jason Farley, August 9, 2018.
126 AH Interview with Lyn Stevens (June 5, 2018).
127 AH Interview with Katie Macomber, Michigan (May 24, 2018); Interview with Melody Wilkinson, August 22, 2018.
128. Walgreens, "Learn About PrEP." https://www.walgreens.com/topic/pharmacy/healthcare-clinic.jsp
129. Tung et al., "Feasibility of a Pharmacist-Run HIV PrEP Clinic in a Community Pharmacy Setting" (CROI 2018). http://www.croiconference.org/sessions/feasibility-pharmacist-run-hiv-prep-clinic-community-pharmacy-setting
130. *Id.*
131. *Id.*
132. Cody Shafer, "Pharmacist-Partnered PrEP Delivery." https://www.nastad.org/sites/default/files/Mega-Meeting-Slides/pharmacy-based_hiv-hcv_prevention_delivery_-_cody_shafer.pdf
133. *Id.*
134. National Conference of State Legislatures, "Medication Therapy Management: Pharmaceutical Safety and Savings" (Updated Oct. 2016). http://www.ncsl.org/research/health/medication-therapy-management.aspx
135. HRSA, "What is a Health Center?" https://bphc.hrsa.gov/about/what-is-a-health-center/index.html.
136. MACPAC. Medicaid Payment Policy for Federally Qualified Health Centers (Dec. 2017). https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf
137. CMCS Informational Bulletin: State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception (Apr. 2016). https://www.medicaid.gov/federal-policy-guidance/downloads/cib040816.pdf
138. Kaiser Family Foundation, "Medicaid Benefits: Rural Health Clinic Services" (2012). https://www.kff.org/medicaid/state-indicator/rural-health-clinic-services/
139. Interview with Erin Loubier, Juan-Carlos Loubriel, and Megan Coleman, August 7, 2018.
140. Interview with Sara Rosenbaum, August 14, 2018.
141. Interview with Erin Loubier, Juan-Carlos Loubriel, and Megan Coleman, August 7, 2018.
142. Interview with Leighton Ku, September 5, 2018.
143. *Id.*
144. Interview with Matt Salo, August 20, 2018.
145. Interview with Stephen Cha, August 6, 2018.
146. AcademyHealth interview with Doug Wirth, June 11, 2018.
147. Press Release, "NYS Medicaid Special Needs Health Plans (SNPs) to Expand Access to All Medicaid-Eligible Transgender Individuals Regardless of HIV Status" (Nov. 1, 2017). mysocialgoodnews.com/nys-medicaid-special-needs-health-plans-snps-expand-access-medicaid-eligible-transgender-individuals-regardless-hiv-status/
148. AcademyHealth interview with Doug Wirth, June 11, 2018.
149. *Id.*
150. National Coalition of STD Directors, "Extragenital Testing" (April 2017). www.ncsddc.org/resource/extragenital/
151. Health Management Associates for the Association for Community-Affiliated Plans, "Strategies to Increase MAT Prescribing" (May 2018). https://www.communityplans.net/research/strategies-to-increase-mat-prescribing/
152. Interview with Jennifer Babcock, August 22, 2018
153. Schulman et al., "Exploring Value-Based Payment to Encourage Substance Use Disorder Treatment in Primary Care" (June 2018). https://www.chcs.org/media/VBP-for-SUD_Final_June-2018.pdf

2019 Prevention Alliance Strategies									
#	**Strategy**	**Lead Organization**	**Description**	**Bill(s)**	**Bill Status**	**Action Item**	**Budget Ask**	**Governor's Budget**	**House Budget**
1	Access to Substance Use Disorder Treatments	WSMA	Increase access to treatment and coverage for health care services; specifically, increased access and funding to services for medically assisted treatments (MAT), increased coverage for MAT services and other 'gold standard' substance use disorder treatment.				Varies	9.8m GF-S/ 67.3m total	
2	Duty to Warn	WSMA	Concerning obligations of mental health professionals.					n/a	
3	Immunization Defense	WithinReach, WSMA	Defend against any legislation or budget item that might emerge during session that would weaken our existing immunization laws.	1019, 1275, 1276				n/a	
4	Help Me Grow	WithinReach	Stat building Help Me Grow out statewide, which includes funding for building out statewide infrastructure to support statewide HMG central access point services for families, technical assistance for HMG implementation, a phased roll out starting with 5 communities, and provider outreach to connect families into HMG.					TBD amount under UHV bucket totaling 38.773m GF-S/ 45.061m total	
5	Behavioral Health	King County	Support budget and policy proposals that advance prevention related to behavioral health prevention				Varies	27.8m GF-S/ 70.8m total; 22.5m capital	
6	Home Visiting	Fight Crimes: Invest in Kids	Invest an additional $9 million in state funding to expand home visiting to 1200 more families. Continue to explore opportunities to leverage Medicaid and Family First Prevention Services Act funding to meet unmet need.				9 m	TBD amount under UHV bucket totaling 38.773m GF-S/ 45.061m total	
7	Active Transportation Safety Advisory Committee	WA Bikes	Create the Active Transportation Safety Advisory Committee (ATSAC). This committee is a merging and continuation of the 2017 Cooper Jones Bicyclist Safety Advisory Committee and the Pedestrian version. The committee will identify recommendations to present to the legislature in an effort to reduce fatalities and serious injuries for people walking and biking.					150k	

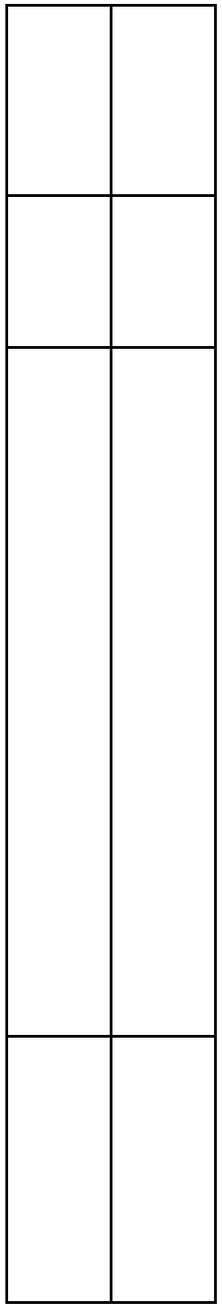
8	Vulnerable Road Users	WA Bikes	Strengthen Washington's vulnerable road users (VRU) law. The current VRU law is ambiguous as to when it's applicable and which penalties should be enforced. This has resulted in a rarely sited VRU law. Additionally, there is a lack of awareness of the law among law enforcement, prosecutors and the public.					n/a	
9	Funding for Active Transportation	WA Bikes	Look for opportnities to increase funding for active transportation strategies (SRTS, bike and ped grants and network connectivity). Protection of current levels of funding for SRTS and bike and ped grants.					TBD amount under practical solutions bucket totaling 13m	
10	Preventing Gun Violence	Alliance for Gun Responsibility	Advocate for a policy agenda built around helping to keep our communities and families safe from gun violence. Key policies include continuing to close loopholes and strengthen our background check system, expanding the ability to have gun free zones in places like hospitals early learning centers, parks and libraries, strengthening our systems to help keep firearms out of the hands of people in crisis and investing in public health gun violence prevention research.	5027, 1068/ 5062, 1073/ 5061		*5027:* sign in **PRO** S Law & Justice 1/17 @ 10:00 *5062:* sign in **PRO** S Law & Justice 1/21 @ 10:00 *1068* : sign in **PRO** H Civil Rights 1/22 @ 10:00 *1073:* sign in **PRO** H Civil Rights 1/22 @ 10:00		114k GF-S/ 175k total - Gun list incident report	
11	Foundational Public Health Services	Public Health Roundtable, King County	The Governmental Public Health system is asking for funding for communicable disease, environmental health and assessment activities throughout the State. The cost to fully fund these services is $295 million for the biennium. The System is currently prioritizing the services, so that it will be prepared to receive and spend a smaller amount of dollars in the most effective way possible.				295m	22m	

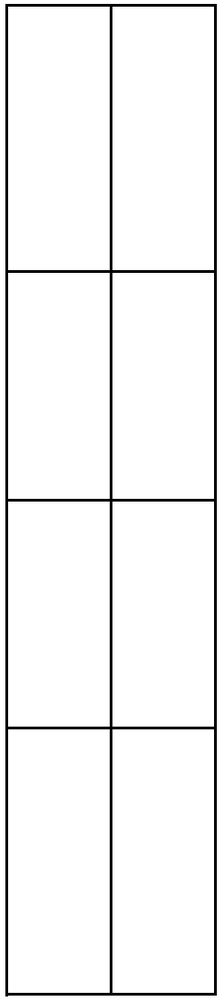
12	Comprehensive School Counselor Programs	School Counselors	Ensure school counselors are empowered to implement comprehensive school counseling programs, eliminating non-counselor duties to ensure they spend 80% of time working directly with students, in accordance with ASCA model. In addition, ensure anyone working as a school counselor has the appropriate licensure for WA state in school counseling (per RCW 28A.410.043).	1265				0	
13	Funding for School Nurses, Counselors, Family & Community Engagement Coordinators, and School Nurse Corps	WSNA	$60 million for K-12 comprehensive supports: more school nurses, middle school counselors, and family and community engagement coordinators. In addition to increased funding for positions like school nurses and school counselors covered under the prototypical school model, the School Nurse Corps also needs to be funded.	5315			60m	126.864m	
14	Student Mental Health	Committee for Children, NAMI WA, School Counselors, Partners for Our Children	Improve student mental health grades k-12 by a combination of bills targeting: 1-student skill development including evidence based SEL and mental health literacy. 2-school personnel training and professional development 3-investments in system capacity.	5082		*5082:* sign in **PRO** S Early Learning 1/18 @ 8:00		7.497m	
15	Family First Prevention Services Act	Partners for Our Children	Support legislation/budget requests related to implementation of the Family First Prevention Services Act (FFPSA), which is a federal law that allows states to draw down dollars (Title IV-E) for parenting programs and other services geared towards preventing placements, which in turn will reduce trauma for children, youth and families and ostensibly prevent future generations from experiencing abuse and/or neglect.	Z.0124.4		sign in **PRO** S Human Svcs 1/17 @ 1:30		n/a	

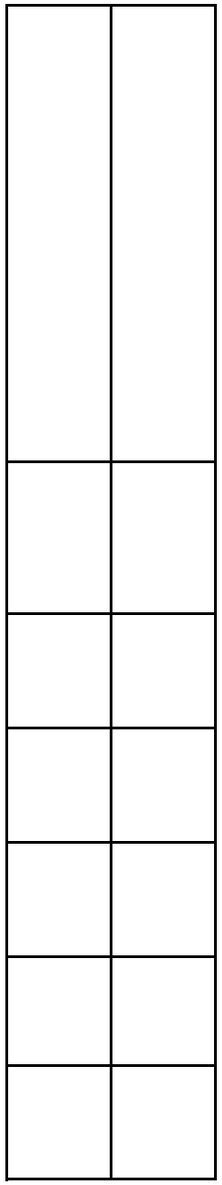
16	Children's Mental Health	Partners for Our Children, Seattle Children's, WCAAP	Support the priorities of the Children's MH Workgroup (TBD) that are likely to include: • Increasing the Medicaid rate • Addressing workforce issues (in addition to the rate) • Improving the PIT process/option • Increasing school based mental health services, including suicide prevention • Expanding partial hospitalization programs (likely through the establishment of an adequate rate) • Implementing PAL • Adopting recommendations re trauma informed early learning • Adopting recommendations re child care consultation	1221				12.1m GF-S/ 41.3m total	
17	Access to Pediatric Care	WCAAP	Reinstitute Medicaid payment to be at equity with Medicare payment to ensure children timely access to health care.	1185, 5319			31m NGFS	56.637m GF-S/ 199.583m total (pediatric & adult PCP rates)	
18	Community Health Workers	Healthy Gen	Support DOH's Decision Package (DP) request of $1.16 million for implementation of 2019 Community Health Worker (CHW) Task Force report.				1.16m	0	
19	Community Based Substance Abuse Prevention	WSAVP	Advocating for community-based substance abuse prevention using revenue from initiative 502				3.5m	0	
20	Access to Care Placeholder	Healthy Gen	Oppose efforts to roll back existing health coverage and support finding state-level solutions that ensure all Washingtonians have access to health care.					n/a	
21	Tobacco 21	ALA, ACS CAN, AHA, CTFK	Raise the minimum legal sale age for tobacco products, including e-cigarettes, to 21 years of age.	1074/ 5057		*5057:* sign in **PRO** S Health 1/18 @ 8:00		8.9m	
22	Funding for Youth Tobacco & Vapor Product Prevention Account	ALA, ACS CAN, AHA, CTFK	Advocate for increased funding for tobacco prevention funding to be used in accordance with CDC best practices				32.6m	0	

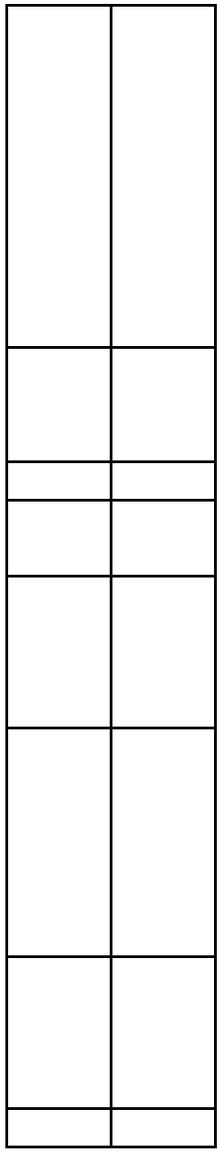
23	SNAP Incentive & EBT System Change	COPC	Support the Department of Health (DOH) decision package for state funding for the Food Insecurity Nutrition Incentives (FINI) program, which offers fruit and vegetable incentives to low income people for use at grocery stores and farmers markets. The FINI DP request is for ~$3.4 million/biennium. In addition, make changes to the EBT system used for SNAP benefits that would allow SNAP incentive dollars to go back onto the EBT card rather than having to rely on a voucher, which is currently the process for FINI program.				3.4m for incentives	2.325m for incentives	
24	Healthy Kids, Healthy Schools	COPC	Secure renewed funding in the Capital Budget for the Healthy Kids, Healthy Schools grant program. OSPI submitted a DP for $6.75 mil per biennium ongoing for this grant program				6.75m	3m	
25	Sugar Policy Placeholder	COPC	Reduce sugar consumption through policy changes					n/a	
26	Washington Wildlife and Recreation Program	WTA	Support the $130 million in funding for the Washington Wildlife and Recreation Program (WWRP) for the 2019-21 biennium.				130m	115m	
27	Housing Trust Fund	WLIHA	The Housing Trust Fund is Washington's primary source of state funding to build safe, healthy, and affordable homes for people living on very low incomes. The specific appropriation ask will be finalized closer to the 2019 legislative session				200m	140m	
28	Pesticide Drift	WSLC	Advancing recommendations to address pesticide drift exposure. It is expected that one of the proposals will be the reinstatement of the Pesticide Incident Reporting and Tracking Panel (PIRT). This effort will allow us to gather baseline information to formulate good public health approaches to the preventable issue of pesticide exposure.				500-750k		
29	Potentially Preventative Hospitalizations	TPCHD	Continue the efforts between Tacoma-Pierce County Health Department and health care providers to implement strategies developed in 2018, build upon them and impact the overall health of the communities in the 27th and 29th legislative districts.				1.34m	0	
30	Homelessness - other			5324					

Senate Budget	**Final Budget**









BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: Z-0126.7/19 7th draft

ATTY/TYPIST: KS:amh

BRIEF DESCRIPTION: Concerning foundational public health services.

AN ACT Relating to foundational public health services; amending RCW 43.70.512; adding a new section to chapter 43.70 RCW; and repealing RCW 43.70.514, 43.70.516, 43.70.520, 43.70.522, and 43.70.580.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 43.70.512 and 2007 c 259 s 60 are each amended to read as follows:

(1) Protecting the public's health across the state is a fundamental responsibility of the state((~~. With any new state funding of the public health system as appropriated for the purposes of sections 60 through 65 of this act, the state expects that measurable benefits will be realized to the health of the residents of Washington. A transparent process that shows the impact of increased public health spending on performance measures related to the health outcomes in subsection (2) of this section is of great value to the state and its residents. In addition, a well-funded public health system is expected to become a more integral part of the state's emergency preparedness system.~~

~~(2) Subject to the availability of amounts appropriated for the purposes of sections 60 through 65 of this act, distributions to local health jurisdictions shall deliver the following outcomes:~~

~~(a) Create a disease response system capable of responding at all times;~~

~~(b) Stop the increase in, and reduce, sexually transmitted disease rates;~~

~~(c) Reduce vaccine preventable diseases;~~

~~(d) Build capacity to quickly contain disease outbreaks;~~

~~(e) Decrease childhood and adult obesity and types I and II diabetes rates, and resulting kidney failure and dialysis;~~

~~(f) Increase childhood immunization rates;~~

~~(g) Improve birth outcomes and decrease child abuse;~~

~~(h) Reduce animal-to-human disease rates; and~~

~~(i) Monitor and protect drinking water across jurisdictional boundaries.~~

~~(3) Benchmarks for these outcomes shall be drawn from the national healthy people 2010 goals, other reliable data sets, and any subsequent national goals~~)) and is accomplished through the governmental public health system. This system is comprised of the state department of health, state board of health, local health jurisdictions, sovereign tribal nations, and Indian health programs.

(2)(a) The legislature intends to define a limited statewide set of core public health services, called foundational public health services, which the governmental public health system is responsible for providing in a consistent and uniform way in every community in Washington. These services are comprised of foundational programs and cross-cutting capabilities.

(b) These governmental public health services should be delivered in ways that maximize the efficiency and effectiveness of the overall system, make best use of the public health workforce and evolving technology, and address health equity.

(c) Funding for the governmental public health system must be restructured to support foundational public health services. In

restructuring, there must be efforts to both reinforce current governmental public health system capacity and implement service delivery models allowing for system stabilization and transformation.

NEW SECTION. **Sec. 2.** A new section is added to chapter 43.70 RCW to read as follows:

(1) With any state funding of foundational public health services, the state expects that measurable benefits will be realized to the health of communities in Washington as a result of the improved capacity of the governmental public health system. Close coordination and sharing of services are integral to increasing system capacity.

(2)(a) Funding for foundational public health services shall be appropriated to the office of financial management. The office of financial management may only allocate funding to the department if the department, after consultation with federally recognized Indian tribes, a state association representing local health jurisdictions, and the state board of health, jointly certify to the office of financial management that they are in agreement on the distribution and uses of state foundational public health services funding across the public health system.

(b) If joint certification is provided, the department shall distribute foundational public health services funding according to the agreed-upon distribution and uses. If joint certification is not provided, appropriations for this purpose shall lapse.

(3) By October 1, 2020, the department, in consultation with local health jurisdictions, sovereign tribal nations, and the state board of health, shall report on:

(a) Service delivery models, and a plan for further implementation of successful models;

(b) Changes in capacity of the governmental public health system; and

(c) Progress made to improve health outcomes.

(4) For purposes of this section:

(a) "Foundational public health services" means a limited statewide set of defined public health services within the following areas:

(i) Control of communicable diseases and other notifiable conditions;

(ii) Chronic disease and injury prevention;

(iii) Environmental public health;

(iv) Maternal, child, and family health;

(v) Access to and linkage with medical, oral, and behavioral health services;

(vi) Vital records; and

(vii) Cross-cutting capabilities, including:

(A) Assessing the health of populations;

(B) Public health emergency planning;

(C) Communications;

(D) Policy development and support;

(E) Community partnership development; and

(F) Business competencies.

(b) "Governmental public health system" means the state department of health, state board of health, local health jurisdictions, sovereign tribal nations, and Indian health programs located within Washington.

(c) "Indian health programs" means tribally operated health programs, urban Indian health programs, tribal epidemiology centers, the American Indian health commission for Washington state, and the Northwest Portland area Indian health board.

(d) "Local health jurisdictions" means a public health agency organized under chapter 70.05, 70.08, or 70.46 RCW.

(e) "Service delivery models" means a systematic sharing of resources and function among state and local governmental public health entities, sovereign tribal nations, and Indian health programs to increase capacity and improve efficiency and effectiveness.

NEW SECTION. **Sec. 3.** The following acts or parts of acts are each repealed:

(1)RCW 43.70.514 (Public health—Definitions) and 2007 c 259 s 61;

(2)RCW 43.70.516 (Public health—Department's duties) and 2007 c 259 s 62;

(3)RCW 43.70.520 (Public health services improvement plan—Performance measures) and 2007 c 259 s 64 & 1993 c 492 s 467;

(4)RCW 43.70.522 (Public health performance measures—Assessing the use of funds—Secretary's duties) and 2007 c 259 s 65; and

(5)RCW 43.70.580 (Public health improvement plan—Funds—Performance-based contracts—Rules—Evaluation and report) and 1995 c 43 s 3.

--- END ---

Below is a revised section. I've also included a copy of the section showing all the changes that I made.

NEW SECTION. Sec. 2. A new section is added to chapter 43.70 RCW to read as follows:

(1) State appropriations provided solely for foundational public health services are expected to achieve measurable benefits to the health communities of Washington as a result of improved capacity of the governmental system of public health. *Close coordination and sharing of services are integral to increasing system capacity.*

(2)(a) Funding for foundational public health services shall be appropriated to the office of financial management. The office of financial management may only allocate funding to the department if the department, a state association representing local health jurisdictions, and the state board of health jointly certify to the office of financial management that they are in agreement on the distribution and uses of state foundational public health services funding across the public health system.
(b) If joint certification is provided, the department shall distribute foundation public health services funding according to the agreed upon distribution and uses. If joint certification is not provided, appropriations for this purpose shall lapse.

(3) The department, a state association representing local health jurisdictions, and the board of health shall consult with federally recognized indian tribes on foundational public health services.

(5) *(Insert (3) and (4) text as drafted…)*

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One-Page Summary
FPHS CD Subgroup Assignment from FPHS Steering Committee (1-18-2019)

Guiding Principles
The FPHS CD Subgroup agreed upon the following principles to guide our work:

- Capacity to control communicable diseases or immediately link CD experts to the local situation must be present in all LHJs.
- A center of excellence needs to exist for each communicable disease. The role of the center of excellence is to provide technical support to the entire system and ensure high quality services are delivered to all residents. As a result, the Public health staff investigating each disease, needs to have technical knowledge of the disease along with the skills and ability to work with the affected populations.
- Public health resources for communicable disease control activities should be focused in the areas of the state with the highest number of cases.
- Various service delivery models will be used to perform surveillance and response activities for notifiable conditions that are communicable diseases. These service delivery models are described in the table below.

Overall Priorities
The FPHS CD subgroup communicated the following priorities to the FPHS Steering Committee:

- Continue the **work that was funded from the previous biennium**.
- **Reinforcing capacity** for LHJs.
- **Infrastructure** must be in place for LHJs and DOH to do our work. This includes laboratory support and data systems support (WDRS upgrades and data elements for WAIIS).
- **Disease investigation and response** for general communicable disease, Hep C, HIV, Syphilis, Gonorrhea, and TB.

CD Subgroup Priorities	Proposal ($40M Scenario)	Details
Continue the **work that was funded from the previous biennium**	$15M	• $10M to LHJs for reinforcing capacity • $2M to WASALPHO and DOH • $3M to PHSKC for reinforcing capacity
Reinforcing capacity – allows flexible CD funding for all LHJs	**$10M**	• This doubles last biennium's investment to LHJs for reinforcing capacity
Infrastructure – necessary for all LHJs and DOH to do our work. This includes laboratory support and data systems support (WDRS upgrades and data elements for WAIIS)	**$6M**	• $2M for Lab Support to LHJs/DOH o Supports Foodborne Disease, Hepatitis C, TB testing, and match dollars to leverage 90/10 IAPD Grant • $3M for WDRS Data System Support to LHJs/DOH o Supports basic maintenance and operation and match dollars to leverage 90/10 IAPD Grant • $0.8M for Immunization Data Quality o Includes match dollars to leverage 90/10 IAPD Grant
Addressing the Burden of Disease through Investigation and Response – strengthens LHJ and DOH capacity to respond to general communicable disease, Hepatitis C, HIV, Syphilis, Gonorrhea, and TB using a burden of disease approach	**$24M**	• Allocation to LHJs and DOH will be determined by the FPHS CD Subgroup based on the burden of disease
TOTAL	**$40M**	